No. 80-756

FILED
NOV 1
MICHAEL RODA

In the Supreme Court of the United States

OCTOBER TERM, 1980

PATRICIA R. HARRIS, SECRETARY OF HEALTH AND HUMAN SERVICES, AND ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, PETITIONERS

v.

GRAY PANTHERS

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

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QUESTION PRESENTED

Whether regulations of the Secretary of Health and Human Services governing the extent to which certain states that participate in the Medicaid program may consider the income of an applicant's spouse in determining eligibility for and the amount of Medicaid assistance are arbitrary, capricious, or otherwise unlawful.

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The Solicitor General, on behalf of the Secretary of Health and Human Services and the Administrator of the Health Care Financing Administration, petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the District of Columbia Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App. A, *infra*, 1a-17a) is not yet reported. The opinion of the district court (App. E, *infra*, 23a-30a) is reported at 461 F. Supp. 319.

JURISDICTION

The judgment of the court of appeals (App. D, *infra*, 21a-22a) was entered on July 29, 1980. On October 20, 1980, the Chief Justice extended the time in which to petition for a writ of certiorari to and including November 10, 1980. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY PROVISIONS AND REGULATIONS INVOLVED

Section 1902(a)(17) and (f) of the Medicaid Act, 42 U.S.C. 1396a(a)(17) and (f), the regulations invalidated by the court of appeals (42 C.F.R. 435.734, 436.602, 436.711, and 436.821), and 42 C.F.R. 435.723 are reprinted, in pertinent part, in App. H, *infra*, 35a-38a.

STATEMENT

1. The Medicaid program was established in Title XIX of the Social Security Act, 42 U.S.C. 1396 *et seq.*, "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris* v. *McRae*, No. 79-1268 (June 30, 1980), slip op. 1-2. As adopted in 1965, Title XIX required participating states to provide medical assistance to individuals who received cash assistance under any of

the four "categorically needy" assistance programs established in the Social Security Act.[1] Under Section 1902(a)(17) of the Act, 42 U.S.C. 1396a(a)(17), each participating state was required to adopt "reasonable standards * * * for determining eligibility for and the extent of medical assistance," taking into account "only such income and resources as are * * *available to the applicant or recipient." Furthermore, in response to practices that had been adopted by states in administering the medical assistance plans established under the predecessor Kerr-Mills program, Congress required participating states to refrain from taking into account "the financial responsibility of any individual for any applicant or recipient of assistance * * * *unless such applicant or recipient is such individual's spouse*" or minor, blind, or disabled child. 42 U.S.C. 1396a(a)(17)(D) (emphasis added).

With the approval of the Secretary of Health, Education, and Welfare (now Health and Human Services), some participating states took the position that it was reasonable to expect an applicant's spouse to help pay the cost of the applicant's medical expenses and, therefore, adopted rules that took into account the income of the spouse in determining Medicaid eligibility and the amount of assistance. These states calculated an amount considered necessary to pay the basic living expense of the applicant's spouse and "deemed" any income of the spouse in excess of that amount as "available" to the applicant. In accordance with Congress' expressed intent that the medical expenses of the "most needy" be met first under the Medicaid pro-

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[1] Old Age Assistance (OAA), Title I, 42 U.S.C. (1970 ed.) 301 *et seq.*; Aid to Families with Dependent Children (AFDC), Title IV, 42 U.S.C. (1970 ed.) 601 *et seq.*; Aid to the Blind (AB), Title X, 42 U.S.C. (1970 ed.) 1201 *et seq.*; Aid to the Permanently and Totally Disabled (APTD), Title XIV, 42 U.S.C. (1970 ed.) 1351 *et seq.* Participating states could also offer medical assistance to the "medically needy"— *i.e.*, individuals whose income was greater than permissible under the categorical assistance plans but inadequate to pay medical expenses. Congress, however, thought it appropriate that the medical expenses of the "most needy" be met before extending benefits to the less needy. See, *e.g.*, S. Rep. No. 404, 89th Cong., 1st Sess. 77 (1965).

gram,[2] the amount considered necessary to pay the basic living expenses of the applicant's spouse was generally set near subsistence level.

In 1972, Congress replaced three of the four categorical assistance programs with a new federal program, Supplemental Security Income for the Aged, Blind, and Disabled (SSI), Title XVI, 42 U.S.C. 1381 *et seq.*[3] From the beginning of the Medicaid program in 1965, participating states were required to provide medical assistance to those individuals receiving benefits under their categorical assistance programs. Adoption of the SSI program was not intended to affect this traditional linkage. But under the SSI program, the states would no longer control the standards of need for the aged, blind, or disabled. The group of individuals who would be eligible for SSI assistance, and therefore eligible for Medicaid assistance, was in some states significantly larger than the group that was eligible under the prior assistance programs for the aged, blind, and disabled. To avoid forcing the states that participated in the Medicaid program to choose among (1) expanding their Medicaid assistance obligations involuntarily, (2) withdrawing from the Medicaid program, and (3) reducing the level of benefits provided under the Medicaid program, Congress offered the states what has come to be called the "209(b) option," 42 U.S.C. 1396a(f).[4] Each state was given the choice of providing medical assistance to all recipients of cash assistance under the SSI program or to the more limited group of individuals who would have been eligible for assistance under the state's Medicaid plan on January 1, 1972.

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[2] See, *e.g.*, S. Rep. No. 404, 89th Cong., 1st Sess. 77, 78–79 (1965); H.R. Rep. No. 213, 89th Cong., 1st Sess. 66, 68 (1965).

[3] As its name indicates, the SSI program replaced the categorical assistance plans for the aged, blind, and disabled. The provisions of the old categorical assistance programs remain in effect in Puerto Rico, Guam, and the Virgin Islands. See Pub. L. No. 92–603, Title III, Section 303(a) and (b), 86 Stat. 1484.

[4] The provision was enacted as Section 209(b) of the Social Security Amendments of 1972, Pub. L. No. 92–603, 86 Stat. 1381.

Under the SSI statute, the income of an applicant's spouse is attributed to the applicant for the purpose of determining eligibility and the amount of assistance.[5] Any state that participates in the Medicaid program but fails to exercise the 209(b) option (an "SSI state") is required to provide medical assistance to all SSI benefit recipients. Because of the relationship between the Medicaid and SSI statutes, and to avoid the unfairness and administrative difficulties involved in permitting individual SSI states to determine Medicaid eligibility by reference to rules different from those applied in determining SSI eligibility, the Secretary issued regulations requiring SSI states to consider the income of an applicant's spouse in making Medicaid determinations only to the extent required by the SSI statute. 42 C.F.R. 435.723.[6]

In addition, the Secretary required 209(b) states to consider the income of an applicant's spouse in determining Medicaid eligibility and the level of benefits at least to the extent that it would be considered in a SSI state. 42 C.F.R. 435.734. Section 209(b) of the 1972 amendments, 42 U.S.C. 1396a(), however, authorizes the states that

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[5] When the applicant and his spouse live in the same household, the income of both is considered in deter ining the eligibility of either for SSI benefits. 42 U.S.C. 1382(a)(2), 1382c(b), (f)(1). When the applicant and his spouse cease to share the same household, the income of the applicant's spouse is no longer considered in determining the applicant's eligibility for SSI benefits, unless the applicant's spouse is an "eligible spouse," as defined in 42 U.S.C. 1382c(b). By definition, no one can remain an "eligible spouse" for more than six months after separation from his spouse. 42 U.S.C. 1382c(b).

[6] For example, without such regulations, if an applicant became eligible for and received SSI benefits because his noneligible spouse no longer lived in his home and therefore her income was not attributed to him, he would be eligible for Medicaid benefits in an SSI state. But if the same individual were unwilling to accept SSI benefits and applied directly to the state Medicaid agency for benefits under a program for the "medically needy" with higher income standards, he might nevertheless be denied medical assistance if the state Medicaid rules continued to take into account the income of his spouse. This discrimination between needy individuals and equally needy individuals who, for their own reasons, are unwilling to accept SSI benefits clearly was not intended by Congress. See 40 Fed. Reg. 60074 (1975).

exercise the 209(b) option to apply the more restrictive eligibility standards of their Medicaid programs that were in effect in January 1972. Therefore, the Secretary concluded that it would be appropriate to allow Section 209(b) states to consider the income of an applicant's spouse to the extent they would have done so under their 1972 Medicaid plans. 42 C.F.R. 435.734.

2. Respondent filed suit in the United States District Court for the District of Columbia, challenging the Secretary's regulations governing the extent to which the income of an applicant's spouse could be considered in making Medicaid determinations in 209(b) states, Puerto Rico, Guam, and the Virgin Islands.[7] Respondent argued that these regulations were inconsistent with Section 1902(a)(17) of the Social Security Act, 42 U.S.C. 1396a(a)(17), and the Due Process Clause of the Fifth Amendment (App. E, *infra*, 26a–27a). Finding the statutory contention dispositive, the district court did not reach respondent's constitutional claims (*id.* at 27a n.3). According to the district court (*id.* at 28a & n.5), Section 1902(a)(17)(D) of the Act, 42 U.S.C. 1396a(a)(17)(D), "may allow a state to enforce its financial responsibility laws against a spouse or parent," but a participating state may not consider any portion of the income of an applicant's spouse to be "available" to the applicant without making an individual determination of the living expenses of the spouse. The court thus held that the challenged regulations were invalid and ordered the Secretary to adopt new regulations "requir[ing] all [209(b) jurisdictions, Puerto Rico, Guam, and the Virgin Islands] to cease the deeming of income for any length of time between institutionalized Medicaid recipients or applicants and their noninstitutionalized spouses * * *" (App. F, *infra*, 31a–32a; App. G, *infra*, 33a–34a).[8]

[7] 42 C.F.R. 435.734, 436.602, 436.711, 436.821 (App. H, *infra*, 36a–38a); see App. E, *infra*, 23a n.2; App. G, *infra*, 33a. Respondent is "a voluntary organization dedicated to improving the treatment accorded our nation's elderly" (App. A, *infra*, 2a). The district court found that respondent had standing to challenge the regulations because some of its members would have standing (App. E, *infra*, 27a n.4).

[8] Given its interpretation of Section 1902(a)(17) of the Act, the district court's invalidation of 42 C.F.R. 435.734 is understandable. The

A divided panel of the court of appeals affirmed, but on grounds other than those relied on by the district court. The court of appeals rejected (App. A, *infra*, 8a) the Secretary's analysis of the pertinent statutory provisions, asserting that "there is no required federal statutory 'deeming' in the 209(b) jurisdictions which are the subject of this case." The court of appeals acknowledged (*id.* at 9a) that the "legislative history of the Medicaid statute explicitly addresses the question of when 'deeming' is proper" and "establishes a broad principle * * * that 'deeming' is appropriate between spouses * * *," but it found (*id.* at 10a) that the legislative history of the statute also "recognizes exceptions to the general rule, requiring individualized factual determinations of availability to be made." Citing this Court's decision in *Citizens to Preserve Overton Park, Inc.* v. *Volpe*, 401 U.S. 402 (1971), the court of appeals held the regulations invalid because the Secretary, in authorizing deeming in 209(b) states, failed to consider all of the factors and policy concerns the court thought "relevant" (App. A, *infra*, 7a). It therefore remanded the case to the district court (*id.* at 13a) "with direction to remand it to the Secretary for promulgation

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basis for the court's invalidation of the regulations applicable in Puerto Rico, Guam, and the Virgin Islands is more difficult to discern. First, 42 C.F.R. 436.602, which is essentially a restatement of Section 1902(a)(17)(D), simply prohibits the consideration of the income of any of the applicant's relatives, except his spouse or (in some circumstances) his parent. Second, 42 C.F.R. 436.711 and 436.821 simply require the relevant Medicaid agencies to apply the financial eligibility requirements that would be applied in determining eligibility under the old categorical assistance plans (see note 1, *supra*), including the extent to which the income of a spouse should be considered. Since Puerto Rico, Guam, and the Virgin Islands are required to provide medical assistance to all categorical assistance recipients (see 42 U.S.C. 1396a(a)(10)(A)) and (except with respect to the "medically needy" and AFDC beneficiaries) are not entitled to federal assistance for providing medical assistance to individuals who are ineligible to receive benefits under the categorical assistance programs, it is difficult to understand how any other rules could be applied. See also note 6, *supra*. The court of appeals also failed to distinguish between the regulations applicable in 209(b) jurisdictions and those applicable in Puerto Rico, Guam, and the Virgin Islands.

without delay of new regulations consistent with the Medicaid statute as interpreted in this opinion."

Judge MacKinnon concurred in part and dissented in part (App. A, *infra*, 13a–17a). Judge MacKinnon agreed that the Medicaid Act permits participating states to attribute the income of one spouse to another. In his view, however, "there is nothing to suggest that the Secretary's action in promulgating the regulations allowing the use of 'deeming' in 209(b) States is arbitrary or capricious, [which is] the limit of our scope of review* * *" (*id.* at 17a; App. C, *infra*, 20a).

REASONS FOR GRANTING THE PETITION

1. The court of appeals' decision in this case is one of four recent circuit court decisions concerning deeming practices under the Medicaid Act. See *Herweg* v. *Ray*, 619 F.2d 1265 (8th Cir. 1980), petition for cert. pending, No. 80–60 (filed July 14, 1980); *Brown* v. *Stanton*, 617 F.2d 1224 (7th Cir. 1980), petition for cert. pending, No. 79–1690 (filed Apr. 25, 1980); *Norman* v. *St. Clair*, 610 F.2d 1228 (5th Cir. 1980), petition for cert. pending *sub nom. Harris* v. *Norman*, No. 80–498 (filed Sept. 27, 1980).[9] Each of these decisions is to some extent irreconcilable with the others.

Although the court of appeals decision in this case is the first to invalidate the HHS regulations applicable in 209(b) jurisdictions for failure to consider all "relevant" factors, in reaching this result the D.C. Circuit rejected the Secretary's analysis of the relationship between the Medicaid statute and the SSI statute as a sufficient basis for the regulations (App. A, *infra*, 7a–8a). According to the court of appeals (*id.* at 8a):

[9] See also *Allen* v. *Califano*, Civ. No. 78–0212 (D. Utah Aug. 23, 1979), appeal pending, No. 79–2167 (10th Cir.) (ordering the Secretary to rescind 42 C.F.R. 435.734 and to issue regulations that require 209(b) states, Guam, Puerto Rico, and the Virgin Islands "to cease assuming the availability of any income that is not in fact available for any length of time" (Order at 2)). The proceedings in *Allen* have been stayed pending consideration of the Secretary's petition for a writ of certiorari in this case.

> It is enough to say that there is no required federal statutory "deeming" in the 209(b) jurisdictions which are the subject of this case, and that there is no justification for extending the antifraud six-month limitation on the general policy beyond its statutory confines.

By contrast, in *Norman* v. *St. Clair*, *supra*, the Fifth Circuit expressly relied on the relationship between the Medicaid and SSI statutes in rejecting the contention that deeming is improper in 209(b) states. The Fifth Circuit explained:

> [U]nder certain circumstances Medicaid eligibility determinations in an "SSI state" must, because of the statutory mandate in the SSI legislation, take into account income that is deemed available, without regard to whether that income is actually contributed. Since this statutory mandate exists concurrently in the Medicaid law with the provision of 42 U.S.C. § 1396a (a)(17) directing that only income which is "available" be taken into account, it must be concluded that the income deemed to Medicaid applicants pursuant to provisions of law applicable to SSI states is available income. A concept of available income which includes income deemed to spouses in SSI states must also encompass income deemed to spouses in the more restrictive programs of the § 209(b) states.

610 F.2d at 1238. Whether or not the Fifth Circuit's reading of the SSI and Medicaid statutes is the only permissible interpretation, it is certainly a reasonable interpretation and one with which the Secretary agrees in substantial part. Yet, the D.C. Circuit has ordered the Secretary to promulgate regulations consistent with its opinion, which effectively precludes reliance on the relationship between the two statutes.

Other related aspects of deeming practices under the Medicaid program have also been the subject of substantial disagreement among the courts of appeals. In *Brown* v. *Stanton*, *supra*, for example, the Seventh Circuit held that Indiana, a 209(b) state, could not consider the income of an applicant's spouse in determining Medicaid eligibility or fixing the level of benefits, if the spouse is unwilling to

contribute to the applicant's medical expenses. Instead, Indiana must ignore the income of the applicant's spouse, advance the full amount of the medical expenses, and then attempt to recoup the overpayment from the reluctant spouse. 617 F.2d at 1230–1231. In *Norman* v. *St. Clair*, *supra*, however, the Fifth Circuit expressly rejected the reasoning adopted by the Seventh Circuit:

> We must reject plaintiffs' contention that 42 U.S.C. § 1396a(a)(17)(D) merely authorizes the states to invoke formal financial responsibility proceedings for the support of spouses. We hold instead that 42 U.S.C. § 1396a(a)(17)(D) permits states to deem income from one spouse available to the other and that such deemed income is part of the "available" income which states may compute under 42 U.S.C. § 1396a (a)(17)(B).

610 F.2d at 1237. But the Fifth Circuit went on to hold that, contrary to the Secretary's regulation (42 C.F.R. 435.734), Mississippi, a 209(b) state, must adopt a "flexible means" test for the purpose of determining what part of the income of an applicant's spouse is "available" to the applicant.[10]

Finally, in *Herweg* v. *Ray*, *supra*, the Eighth Circuit (by an equally divided court) affirmed a district court decision holding that under Section 1902(a)(17) of the Social Security Act, 42 U.S.C. 1396a(a)(17), Iowa, an SSI state, may consider the income of an applicant's spouse without regard to the length of time that the applicant has been separated from his spouse. Since the Secretary was not a party to the proceeding, the district court declined to pass on the validity of the HHS regulations applicable in SSI states. Nevertheless, the district court pointed out that to the extent the regulations limited the time period during which SSI states may consider the income of an applicant's spouse, they are inconsistent with the Medicaid statute. *Herweg* v. *Ray*, 443 F. Supp. 1315, 1320 (S.D. Iowa 1978), aff'd by an equally divided court, 619 F.2d 1265 (8th Cir.

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[10] In *Harris* v. *Norman*, No. 80–498, the Secretary of Health and Human Services seeks review of this aspect of the Fifth Circuit's decision.

1980), petition for cert. pending, No. 80-60 (filed July 14, 1980); see also *Herweg* v. *Ray*, *supra*, 619 F.2d at 1272-1275.

These conflicting decisions are all based, at least in part, upon interpretations of Section 1902(a)(17) of the Social Security Act, 42 U.S.C. 1396a(a)(17). That section is one of the fundamental provisions governing Medicaid eligibility. Consequently, the divergent interpretations of the courts of appeals have posed serious problems for the Secretary in supervising the administration of state Medicaid programs. Because the Court will have the opportunity to resolve the conflict in the circuits concerning the validity of "deeming" under the Medicaid Act this Term (see *Brown* v. *Stanton*, *supra*), it should consider the closely related issue raised in this case as well. If the Court holds that the statute allows deeming, it is important that the form that deeming may take be settled as expeditiously as possible.

These issues have a direct and immediate impact upon the federal and state governments as well as millions of individuals. Every state in the nation, except Arizona, has implemented a medical assistance program under Title XIX of the Social Security Act. United States Department of Health, Education, and Welfare, *Data on the Medicaid Program: Eligibility, Services, Expenditures* 40 & n.3 (1979 ed.). In fiscal year 1977, more than 23 million individuals received federal and state Medicaid payments totalling more than $16 billion (*id.* at 40, 57). The 16 states that have already decided to exercise the Section 209(b) option provided Medicaid benefits to nearly eight million individuals in fiscal year 1977 (*id.* at 57; App. A, *infra*, 4a n.4).[11] The impact of "deeming" practices, however, is not limited to the millions of individuals who currently are eli-

[11] The 209(b) regulations at issue in this case are of significance not only to the states that have already exercised the option provided by Congress in 42 U.S.C. 1396a(f), but also to every other participating state. For example, New York, one of the largest of the participating states, recently decided to exercise the 209(b) option. (New York is now awaiting HHS approval of amendments to its Medicaid plan that would effect the conversion.) Other SSI states are free to follow.

gible for Medicaid notwithstanding the income of their spouses. It is obvious that both the number of individuals who would be eligible for Medicaid assistance and the amount of assistance that would be paid to such individuals will be significantly enlarged if the income of their spouses must be ignored.

It is the Secretary's responsibility to require participating states to provide medical assistance to each qualified applicant with a minimum of administrative delay and cost and to assure that participating states do not receive federal financial assistance for providing medical assistance to any applicant who is not among the intended beneficiaries of the Medicaid program. Because of the conflicting decisions of the courts of appeals, the Secretary now must follow different rules in different states concerning whether "deeming" is permissible at all and, if it is, in what manner and for how long it may be used.

2. Although the court of appeals correctly concluded that the language and legislative history of the Medicaid statute establish the "broad principle" that deeming is appropriate between spouses (App. A, *infra*, 9a), it found that Congress intended an exception to "the seemingly unequivocal expectation that spouses should support each other" (*id.* at 10a) in cases where the spouses are not living together. In reaching this conclusion, the court below noted that Congress expressed the view that Section 1902(a)(17) was designed to prevent the states from assuming the availability of income from absent fathers in reliance on "support orders."[12] According to the court of appeals (App. A, *infra*, 10a), Congress intended to preclude consideration of the absent father's income because "[t]he absence of the father from the home undercuts key assumptions that make 'deeming' ordinarily reasonable, and thus the practice is forbidden." Despite the absence of any reference in the legislative history to absent *spouses*, the court remarked: "Likewise, the absence of a spouse from the home because of institutionalization differs significantly * * * from the situation of cohabiting spouses

[12] See H.R. Rep. No. 213, 89th Cong., 1st Sess. 67 (1965); S. Rep. No. 404, 89th Cong., 1st Sess. 78 (1965).

which is at the heart of the congressional expectation of support" (*ibid.*). As a result, the court held that the Secretary's deeming regulations are invalid for failure expressly to consider these differences.

The court of appeals erred in striking down the Secretary's regulations as inconsistent with the Medicaid Act. As the court acknowledged, the term "available" income in 42 U.S.C. 1396a(a)(17) includes the income of the applicant's spouse "deemed" available to the applicant. Under the SSI statute, the income of an applicant and his spouse is considered in determining eligibility for as long as they live together. See 42 U.S.C. 1382(a)(2), 1382c(b), (f)(1). In determining SSI eligibility, "deeming" may also continue for six months after the applicant and his spouse begin living apart from each other. See 42 U.S.C. 1382(a)(1), 1382c(b), (f)(1). Under the Medicaid statute, each participating state is required to provide medical assistance to all SSI recipients, unless the state exercises the 209(b) option. 42 U.S.C. 1396a(a)(10)(A), (f). It follows, therefore, that SSI states cannot consider the income of an SSI recipient's spouse in making Medicaid determinations if the income would not be considered in making SSI eligibility determinations. Furthermore, because, with exceptions not material here (see note 6, *supra*), participating states are not entitled to federal financial assistance for providing Medicaid benefits to individuals who are ineligible for SSI benefits, it also follows that such states must consider the income of an applicant's spouse in making Medicaid determinations if it would be considered in making SSI determinations.

The Secretary acted reasonably in requiring 209(b) states to follow SSI deeming rules in determining Medicaid eligibility and the amount of assistance. If, in SSI states, the term "available" income, as used in 42 U.S.C. 1396a(a)(17), includes the income of an applicant's spouse to the extent required by the SSI statute, then logically the term should be given the same interpretation in 209(b) states. See *Norman* v. *St. Clair*, *supra*, 610 F.2d at 1238. Moreover, unless 209(b) states are required to consider the income of an applicant's spouse at least to

the extent that it would be considered in an SSI state or under the SSI statute, the congressional intent underlying the 209(b) option would be wholly frustrated. The 209(b) option was intended solely to permit participating states to *exclude* from coverage individuals who would be eligible under the SSI criteria, and therefore eligible for Medicaid coverage (see 42 U.S.C. 1396a(a)(10)(A)), but who would not have been eligible under the more restrictive standards of the states' 1972 Medicaid plans. See S. Rep. No. 92-1230, 92d Cong., 2d Sess. 222 (1972); S. Rep. No. 95-553, 93d Cong., 1st Sess. 56 (1973). Hence, the purpose of the 209(b) option was to avoid imposing *expanded* Medicaid obligations on participating states as a result of the more liberal SSI eligibility requirements. The option was not intended to permit 209(b) states to receive federal aid for providing medical assistance to individuals who would not be eligible even under the more liberal SSI criteria. See, *e.g.*, S. Rep. No. 92-1230, *supra*, at 222.

In addition, the Secretary's regulations permitting 209(b) states to take the income of an applicant's spouse into account to the extent that they would have done so under their 1972 Medicaid plans are also consistent with the statute. Section 1902(a)(17) permits participating states to consider the income of an applicant's spouse as "available" to the applicant for the purposes of determining eligibility and the amount of assistance under the Medicaid program. If the eligibility criteria of a 209(b) state's 1972 Medicaid plan are valid, the Secretary has no power under the statute to require the state "to provide medical assistance to any aged, blind, or disabled individual * * * unless such State would be (or would have been) required to provide medical assistance to such individual * * * had its plan for medical assistance approved under this subchapter and in effect on January 1, 1972, been in effect * * *." 42 U.S.C. 1396a(f).[13] Having approved each of the state Medicaid plans in effect on January 1, 1972, the Secretary was not obliged to reconsider all of the varying circumstances in which state

[13]The 209(b) "spend-down" provision qualifies this statement to some extent but is not pertinent here.

deeming practices would be applied before promulgating the 209(b) regulations challenged in this case. The regulations merely permit 209(b) states to consider the income of an applicant's spouse to the extent that they would have done so under their 1972 Medicaid plans—as Congress intended by enacting the 209(b) option.

The regulations applicable in 209(b) jurisdictions thus are based on the Secretary's sound analysis of the pertinent statutory provisions and due regard for the practical and equitable administration of a nationwide social welfare program. See *Califano* v. *Jobst*, 434 U.S. 47, 53 (1977). But even if the regulations were not *required* by the relationship between the Medicaid program and the various categorical assistance programs, the court of appeals erred in invalidating the regulations. The Secretary is specifically authorized to establish standards for determining what is "available" income for purposes of the Medicaid program. 42 U.S.C. 1396a(a)(17). The SSI statute provides an appropriate model because the eligibility criteria for Medicaid have consistently been tied to eligibility under the categorical assistance programs. Similarly, even if the language of 42 U.S.C. 1396a(f) did not *require* the Secretary to permit the 209(b) states to use the deeming rules in effect in 1972, the provision provides ample support for the Secretary's decision to do so. As this Court pointed out in a similar context, "[a] reviewing court is not free to set aside [such] regulations simply because it would have interpreted the statute in a different manner." *Batterton* v. *Francis*, 432 U.S. 416, 425 (1977). The Secretary's regulations are entitled to legislative effect, unless it can be said that they are arbitrary, capricious, or otherwise unlawful. *Id.* at 425–426.

Contrary to the court of appeals' conclusion, nothing in the legislative history of the Medicaid statute supports a general absent-spouse exception to the "broad principle" that deeming is appropriate between spouses. The court below relied on the following statement in the House Report accompanying the bill that became Title XIX of the Social Security Act (App. A, *infra*, 10a):

> [Section 1396a(a)(17) is] designed so that the States will not assume the availability of income which may

> not, in fact, be available or over-evaluate income and resources which are available. Examples of income assumed include support orders from [*sic*] absent fathers, which have not been paid or contributions from relatives which are not in reality received by the needy individual.

H.R. Rep. No. 213, 89th Cong., 1st Sess. 67 (1965).[13] The court's reliance on this passage was misplaced.[14]

This case involves only the deeming of income between spouses—more precisely, the deeming of income between an institutionalized applicant and his spouse. The language of the statute, 42 U.S.C. 1396a(a)(17)(D), permits consideration of the income of an applicant's spouse. Moreover, the legislative history of the statute clearly indicates that Congress thought it appropriate to require the husband or wife of a Medicaid applicant to help pay the medical expenses of the applicant. See H.R. Rep. No. 213, *supra*, at 68; S. Rep. No. 404, *supra*, at 78. Nowhere in the voluminous legislative hearings, reports or debates is there any suggestion of an absent-spouse exception.[15] In these circumstances, the isolated statement in the House Report disapproving the policy of assuming that an applicant has income on the basis of a "support order" directed to his

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[13] See also S. Rep. No. 404, *supra*, at 78.

[14] Whether or not this snippet of legislative history would have required the Secretary to prohibit consideration of the income of an absent father is not a question raised in this case. In any event, HHS regulations only require 209(b) states to consider the income of an applicant's parent if the applicant is (1) living with his parent and (2) under age 18 or a student and under age 21. See 42 C.F.R. 435.734, 435.724. In accordance with 42 U.S.C. 1396a(f), however, if under a state's 1972 Medicaid plan the income of a parent would have been considered under additional circumstances, the state may continue to do so.

[15] The reference in the House Report to "contributions from relatives which are not in reality received by the needy individual" cannot be read to support a general absent-spouse exception. Congress expressly addressed that problem in 42 U.S.C. 1396a(a)(17)(D), prohibiting consideration of any relative's financial responsibility for the applicant, *except* the applicant's spouse or, in some circumstances, the applicant's parent.

absent father is insufficient to support the conclusion that the Secretary's regulations regarding *spouses* are inconsistent with the Medicaid Act.[16] Rather, "this is a case in which the meaning of [the] statute may be determined by the admittedly old-fashioned but nonetheless still entirely appropriate 'plain meaning' canon of statutory construction." *United States* v. *Clarke*, No. 78-1693 (Mar. 18, 1980), slip op. 1.

To be sure, the court of appeals' reading of the legislative history of the statute is not implausible. But that is not a sufficient basis for finding that the Secretary's current regulations are arbitrary, capricious, or otherwise unlawful. As the court of appeals observed (App. A, *infra*, 12a), "Congress has stated that it is the primary responsibility of the Secretary, and not the courts, to determine whether and to what extent 'deeming' is to be permitted from an individual to his or her institutionalized spouse." It should be emphasized that the regulations permitting 209(b) states to consider the income of an applicant's spouse to the extent that they would have done so under their 1972 Medicaid plans were adopted in light of a statutory provision, 42 U.S.C. 1396a(f), that was specifically intended to avoid state withdrawals from the Medicaid program. Without substantially greater support than that relied on by the court of appeals in this case, a court should be particularly reluctant to invalidate such regulations. See *Batterton* v. *Francis*, *supra*, 432 U.S. at 431-432.[17]

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[16] The court of appeals' reliance on the reference in the House Report to "support orders" directed to "absent" fathers is particularly inappropriate in this case. Unlike the situation of a father who abandons his child and who must be directed by a court to provide financial support for the child, this case involves spouses who are separated solely because of the necessary institutionalization of one of them. Under these circumstances, the separation does not even suggest abandonment or the break down of the marital relationship.

[17] *Citizens to Preserve Overton Park, Inc.* v. *Volpe*, *supra*, provides no support for the court of appeals' position. In *Overton Park*, this Court held that where it was asserted that an agency failed to consider factors *expressly* required by the relevant statutes, review of agency

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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action cannot be based on "'*post hoc*' rationalizations" presented in litigation affidavits. 401 U.S. at 419–421. Here, however, respondent has never contended that the Secretary failed to consider any factor expressly prescribed in the Medicaid statute and, indeed, never relied on *Overton Park* in the courts below. Neither the language of the Medicaid statute nor its legislative history suggests that the Secretary's regulations prescribing what can be considered "available" income are arbitrary or capricious. *Overton Park* cannot be read to permit courts to invalidate regulations solely on the ground that factors or policy concerns the particular court thinks relevant were not expressly considered by the agency.

APPENDIX A

In the United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 79-1334

GRAY PANTHERS

v.

ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL., APPELLANTS

Appeal from the United States District Court
for the District of Columbia

(D.C. Civil Action No. 78-0661)

Argued January 15, 1980

Decided July 29, 1980

Before WRIGHT, *Chief Judge*, MACKINNON, *Circuit Judge*, and MARKEY,* *Chief Judge, United States Court of Customs and Patent Appeals.*

Opinion for the court filed by *Chief Judge* WRIGHT.

Opinion concurring in part and dissenting in part filed by *Circuit Judge* MACKINNON.

WRIGHT, *Chief Judge:* This appeal is from a successful challenge to regulations of the Department of Health and Human Services[1] which implement the Medicaid program

* Sitting by designation pursuant to 28 U.S.C. § 293(a) (1976).

[1] This action was filed before the redesignation of the Department of Health, Education, and Welfare as the Department of Health and Human Services. *See* 20 U.S.C.A. § 3508 (Supp. 1980).

and which involve the financial eligibility criteria for institutionalized individuals and their spouses. Plaintiff-appellee is Gray Panthers, a voluntary organization dedicated to improving the treatment accorded our nation's elderly. The regulations in question permit, among other things, a certain amount of a spouse's funds to be "deemed" available for use by the institutionalized individual, whether or not such funds are in fact provided. Because "deeming" applies "an arbitrary formula, unrelated to the expenses of a particular couple's needs," the District Court held the practice to be forbidden by a statutory requirement that only income available in fact be taken into account for Medicaid eligibility purposes. It therefore vacated the regulations and remanded them to the Secretary for reconsideration. *See Gray Panthers v. Secretary, Dep't of Health, Educ. & Welfare*, 461 F. Supp. 319, 323 (D. D.C. 1978). We agree with the result reached by the District Court but not for its assigned reasons. We believe the Secretary has failed to consider all the relevant factors in determining whether "deeming" is proper in this context. We therefore affirm the judgment of the District Court which vacated the regulations as invalid, but order the case remanded to the Secretary for reconsideration consistent with this opinion.

I

Medicaid is a cooperative federal-state program established pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.* (1976). Regulations promulgated in accordance with the Act supplement the statutes in providing a framework within which the states must operate their Medicaid programs. A state is not required to establish a Medicaid program, but should it do so the program must conform to federal requirements. 42 U.S.C. § 1396a. A "State plan" must be submitted to and approved by the Secretary. 42 U.S.C. § 1396a(b). The state then becomes entitled to federal funds which partially reimburse expenditures made to provide specific types of medical assistance. Section 1902 of the Social Security Act, 42

U.S.C. § 1396a, provides the statutory guideline to which state medicaid eligibility criteria must conform:

> (a) Contents
>
> A State plan for medical assistance must—
>
> * * * * *
>
> (17) include reasonable standards * * * for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient * * *, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child * * *[.]

In addition to providing this general framework for Medicaid eligibility criteria, the statute places limits on the specific provisions that the states may adopt. States may choose to be governed by one of two rules in this regard. First, 42 U.S.C. § 1396a(a) provides that Medicaid assistance must be made available to all individuals who qualify for cash benefits under the Supplemental Security Income (SSI) program, Title XVI of the Social Security Act, 42 U.S.C. § 1381 *et seq.* (1976). In these "SSI states" Medicaid eligibility is determined by statute in accordance with uniform federal standards.

States electing to be governed by the second rule, however, are not required to conform to the explicit SSI criteria. Pursuant to the "209(b) option,"[2] 42 U.S.C. § 1396a(f), any state may choose to establish more stringent eligibility criteria, so long as the criteria are no more restrictive than those in the state's "categorical assist-

[2] The option is so named because it was added by § 209(b) of the 1972 amendments to the Social Security Act, Pub. L. No. 92-603, 86 STAT. 1484.

ance"[3] program that was validly in effect on January 1, 1972. Such programs were the precursors to the SSI program. They were enacted and administered by states in cooperation with the federal government, and their eligibility criteria varied from state to state. This case challenged only the HHS regulations permitting "deeming" in the 209(b) jurisdictions[4] whose eligibility criteria are not explicitly prescribed by federal statute.

A bit of history is necessary to understand the purpose behind the 209(b) option. Before the option was enacted, creating the SSI and 209(b) classifications, all jurisdictions were treated alike for purposes of establishing Medicaid eligibility criteria. Each state was required to provide Medicaid assistance to any individual who qualified for its categorical assistance program. When Congress brought most of these programs under federal administration through enactment of SSI, this principle of automatic eligibility was retained. But the federal SSI eligibility criteria allowed for broader coverage than that provided by many of the state plans. As a result, states would have been forced to expand their Medicaid programs involuntarily, and in some cases significantly. "[I]n order not to impose a substantial fiscal burden on these States," S. Rep. No. 93-553, 93d Cong., 1st Sess. 56 (1973), and to avoid the threat that some states would withdraw from

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[3] The categorical assistance programs were established by various subchapters of the Social Security Act then in effect: Old-Age Assistance, Title I, 42 U.S.C. § 301 *et seq.*; Aid to Families with Dependent Children, Title IV, 42 U.S.C. § 601 *et seq;* Aid to the Blind, Title X, 42 U.S.C. § 1201 *et seq;* and Aid to the Permanently and Totally Disabled, Title XIV, 42 U.S.C. § 1351 *et seq.* Titles I, X, and XIV were subsequently repealed (except in Guam, Puerto Rico, and the Virgin Islands) by the 1972 amendments to the Social Security Act that established SSI, Pub. L. No. 92-603, § 303(a) & (b), 86 STAT. 1484 (effective Jan. 1, 1974). *See* discussion *infra.*

[4] Fifteen states have exercised the 209(b) option: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Utah, and Virginia. In addition, the same regulations apply to the island jurisdiction of Guam, Puerto Rico, and the Virgin Islands, to which the SSI program never applies. *See* note 2 *supra.*

the Medicaid program entirely rather than fund the expanded coverage, *see West v. Cole*, 390 F.Supp. 91, 98 (N.D. Miss. 1975), Congress enacted the 209(b) option. Electing states could thus prevent extension of Medicaid coverage to any persons not then entitled to benefits.[5]

"Deeming" is a procedure used in determining an applicant's financial eligibility for Medicaid. A certain amount of the non-institutionalized individual's funds is conclusively presumed—is "deemed"—to be available for contribution toward the cost of his or her spouse's institutionalization. In SSI jurisdictions "deeming" is specifically required by statute. The statute provides that the income and resources of two cohabiting spouses are to be pooled for purposes of determining the financial eligibility of either. 42 U.S.C. § 1382(a)(2). In other words, income earned by one spouse is conclusively presumed to be earned jointly by the couple, and all such jointly earned income in excess of the statutorily prescribed maintenance level for the couple is considered to be available to either spouse. Where both spouses are otherwise eligible for Medicaid,[6] and one spouse is institutionalized, the pooling of funds continues for six months. The effect of this scheme is thus to "deem" a portion of the non-institutionalized individual's income and resources to be available for support of his or her spouse. After six months of institutionalization only the income and resources of the institutionalized spouse are considered for determining eligibility, and the "deeming" ceases. 42 U.S.C. § 1382c(b). Where only one of the spouses is otherwise Medicaid-eligible, pooling of income must cease with the first month after institutionalization. 42 U.S.C. § 1382c(f).

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[5] This statement is qualified by the fact that 209(b) jurisdictions *were required to enact "spend down"* provisions, whose effect would be to extend Medicaid coverage to some persons not eligible on January 1, 1972. A "spend down" provision deducts funds spent toward medical care from those otherwise considered available for purposes of determining Medicaid eligibility.

[6] That is, aged, blind, or disabled so as to qualify the applicant for relief under the SSI program. *See* 42 U.S.C. § 1381a.

By contrast, "deeming" in the 209(b) jurisdictions at issue in this case proceeds in a more direct manner, although actual practices vary considerably. Typically, the state specifies a "maintenance" level of income and resources for the noninstitutionalized spouse. Any funds in excess of this figure are conclusively presumed to be available for contribution toward the costs of institutionalization. In most states direct Medicaid payments to the institution are automatically reduced by this excess amount. Required medical care is thus usually withheld or terminated if the "deemed" amount is not in fact paid by the noninstitutionalized spouse.[7] The HHS regulations in question permit this "deeming" to occur in each state to the extent that it was the state's practice on January 1, 1972.

II

A

This court's review of the regulations in question must proceed within narrow bounds. The Medicaid statute provides that "available" income and resources shall be "as determined in accordance with standards prescribed by the Secretary[.]" 42 U.S.C. § 1396a(a)(17)(B). Where, as here, Congress has explicitly entrusted to the agency the primary task of defining statutory language, that definition is "entitled to more than mere deference or weight. It can be set aside only if the Secretary exceeded his statutory authority or if the regulation is 'arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with

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[7] Of the 209(b) states only Minnesota appears to be an exception: "The local welfare agency shall not withhold, delay or deny Medical Assistance because a responsible relative deemed able to contribute fails or refuses to accept financial responsibility." 12 Minn. Code of Agency Rules § 2.047 (Dep't of Public Welfare 47) C.5.b.(5). In *Brown v. Stanton*, ___ F.2d ___ (7th Cir. No. 79-1459, decided Jan. 30, 1980), the Seventh Circuit imposed a similar rule on the operation of the Indiana Medicaid program as a matter of statutory interpretation of § 1396a(a)(17). Because of our disposition in this case, we have no occasion to comment on the Seventh Circuit's holding in *Brown*.

law.' 5 U.S.C. §§ 706(2)(A), (C)." *Batterton v. Francis*, 432 U.S. 416, 426 (1977). *See Herweg v. Ray*, 619 F.2d 1265 (1980) (equally divided court sitting *en banc*) (opinion of McMillian, J.). Although this is a narrow standard, it does not relieve the court of its duty to conduct a searching inquiry. Even where no specific statutory requirements are being enforced, the court "must consider whether the decision was based on a consideration of the relevant factors * * *." *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 416 (1971). *See Kollett v. Harris*, 619 F.2d 134, 140 (1980). Because we conclude that the Secretary has not taken the relevant factors into account in promulgating the regulations at issue in this case, the District Court's judgment vacating those regulations must be upheld.

B

The Secretary argues primarily that no internally consistent interpretation of the Medicaid statute can prohibit "deeming" in 209(b) jurisdictions. In SSI jurisdictions "deeming" is required by statute for six months.[8] SSI jurisdictions, like 209(b) jurisdictions, are governed by the requirement of Section 1396a(a)(17) that only "available" income be considered in determining eligibility for benefits. Because "available" income incorporates "deeming" in SSI jurisdictions, the Secretary argues, the same term cannot be defined to prohibit the practice in 209(b) jurisdictions. "A concept of 'available income' which includes income 'deemed' in SSI states for a six month period *must also* encompass income 'deemed' to institutionalized spouses in the '209(b) states.'" Brief for appellants at 14 (emphasis in original).

We do not believe the statutorily required "deeming" in SSI states should be given such dispositive weight with respect to 209(b) jurisdictions. We perceive the governing principle in SSI states to be that the institutionalized individual is to be held solely responsible for his or her own

[8] *See* p. 6 *supra*.

medical care, with "deeming" a very narrow exception.[9] *See* 42 U.S.C. § 1382(a)(1). The six-month "deeming" period appears in the statute as a limitation on the availability of cash payments under the SSI program. *See* 42 U.S.C. § 1382c(b). That limitation might well apply for Medicaid purposes in SSI jurisdictions, which have incorporated in full the SSI eligibility criteria. But it does not reflect a decision by Congress that "deeming"—for six months or for any period of time—is necessarily an appropriate practice in the 209(b) jurisdictions that are the subject of this case. More important, the legislative history shows that the six-month "deeming" provision was designed to serve the limited purpose of deterring fraud in the form of a voluntary separation of spouses in order to receive increased benefits. *See* H.R. Rep. No. 92-231, 92d Cong., 2d Sess. 150 (1971). By its own terms, for example, Section 1382c(b) does not apply where only one of the spouses is otherwise eligible[10] for Medicaid. And there is no indication that its propriety was considered in the context of separations caused by institutionalization, where fraud is presumably not a concern. In any event, the relationship between Section 1396a(a)(17) and the statutory "deeming" in SSI states is not now before the court, and we intimate no opinion with respect to it. It is enough to say that there is no required federal statutory "deeming" in the 209(b) jurisdictions which are the subject of this case, and that there is no justification for extending the antifraud six-month limitation on the general policy beyond its statutory confines.[11]

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[9] HHS itself recognizes that "only in highly limited situations does 'deeming' apply to physically separated relatives and then only when they can be said to be 'constructively' members of the same household[.]" *See* 42 FED. REG. 2685 (1977). Further, this six-month period applies *only* where the noninstitutionalized spouse is also Medicaid-eligible. This fact takes on significance in a different context. *See* discussion immediately following.

[10] *See* text at note 5 *supra*.

[11] The extension of the six-month "deeming" suggested by the government would be twofold: first in the application of the policy to

The Secretary further argues that enactment of the 209(b) option, which permitted states to continue to use their 1972 Medicaid eligibility criteria, amounted to a specific congressional approval of those criteria. Because some states used "deeming" in 1972, the Secretary concludes, the practice was sanctioned by Congress and cannot now be prohibited by this court. Although this is certainly a plausible argument, there is nothing in the legislative history of Public Law No. 92-603, 86 STAT. 1484, to support it. The purpose of the 209(b) option was only to ensure that enactment of the SSI program, with its more generous eligibility criteria, would not automatically increase a state's Medicaid burden.[12] Congress was not expressing its view that "deeming," as then practiced in state Medicaid programs, was consistent with the requirements of the Medicaid statute. We thus agree with the Fifth Circuit's declaration that the 209(b) option cannot be read as an "all-purpose 'grandfathering' clause which effectively legitimizes any and every provision appearing in a state plan in 1972." *See Norman v. St. Clair*, 610 F.2d 1228, 1235 (1980).

C

We turn now to a discussion of the factors that are relevant to the Secretary's ultimate determination of whether and to what extent "deeming" should be permitted from an individual to his or her institutionalized spouse. The legislative history of the Medicaid statute explicitly addresses the question of when "deeming" is proper. It establishes a broad principle, or expectation, that "deeming" is appropriate between spouses and from parents to children: "Your committee believes it is proper to expect spouses to support each other and parents to be held accountable for the support of their [Medicaid-eligible] children * * *." H.R. Rep. No. 213, 89th Cong.,

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209(b) jurisdictions where it is not required by statute, and second in the sense that the HHS regulations permit the policy to be applied in 209(b) jurisdictions beyond the statutory six-month durational limit.

[12] *See* p. 5 *supra*.

1st Sess. 68 (1965); S. Rep. No. 404, 89th Cong., 1st Sess. 78 (1965). But with equal clarity the legislative history recognizes exceptions to the general rule, requiring individualized factual determinations of availability to be made:

> [Section 1396a(a)(17) is] designed so that the States will not assume the availability of income which may not, in fact, be available or overevaluate income and resources which are available. Examples of income assumed include support orders from [*sic*] absent fathers, which have not been paid or contributions from relatives which are not in reality received by the needy individual. * * *

H.R. Rep. No. 213, *supra*, at 67. The question for the Secretary is how the policies underlying the general rule and its exceptions are to be applied to the diverse factual situations posed in this case.

At first blush the facts here presented appear to be embraced by the seemingly unequivocal expectation that spouses should support each other. But Congress has demonstrated that a much more flexible approach must be taken. Parents of Medicaid-eligible children, for example, are under a similarly unqualified expectation of support. And yet the legislative history specifically excludes from "deeming" support from *absent* fathers. The absence of the father from the home undercuts key assumptions that make "deeming" ordinarily reasonable, and thus the practice is forbidden. Likewise, the absence of a spouse from the home because of institutionalizaton differs significantly in two respects from the situation of cohabiting spouses which is at the heart of the congressional expectation of support.

First, the general rule of mutual support proceeds from the assumption that the spouses maintain a common household, "sharing" income and expenses, *see* 42 FED. REG. 2685, 2686 (1977), and constituting a single economic unit. But where institutionalization has caused one spouse to be absent from the home, two households, not one, in effect must be maintained. Expenses can no longer fairly

be characterized as jointly incurred, and "deeming" no longer accurately reflects the economic norm. An important condition that makes "deeming" ordinarily reasonable between spouses is thus not met.

Second, and more important, the limited potential for disruption of the family was a determinative factor in permitting "deeming" between spouses and from parents to children. "Beyond such degree of relationship, however, requirements [of support] imposed are often destructive and harmful to the relationships among members of the family group." S. Rep. No. 404, *supra*, at 78; H.R. Rep. No. 213, *supra*, at 68. The legislative history of Section 1396a(a)(17) recognizes that, especially in the context of the family structure, great care must be exercised to ensure that governmental regulation does not needlessly disrupt people's lives. In contrast with the ordinary situation of cohabiting spouses, institutionalized individuals and their husbands or wives are particularly vulnerable to the disruptive forces than can be exerted by governmental regulations. In most cases the individual's continued institutionalization depends upon his or her spouse's ability (or willingness) to pay the "deemed" amount.[13] The spouse is thus faced with the "choice" of reducing his or her standard of living to a point apparently set near the poverty line, or being responsible for the eviction of his or her spouse from the institution.[14] The institutionalized individual is often literally helpless to temper the harshness of this dilemma.

These two distinctions appear whenever one spouse has been institutionalized. Their importance depends upon the circumstances of each case. It is entirely possible, for example, that the Secretary would choose to treat spouses who were living apart before the institutionalization differently from spouses who were living together. Similarly, whether support payments were being made on a regular

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[13] *See* text at note 6 *supra*.

[14] One "alternative" to payment of the "deemed" amount is divorce. We do not consider this an acceptable option to mitigate the potential disruptive effect of "deeming" in this context.

basis from one separated spouse to the other might itself prove to be a determinative factor. There are many factual differences with respect to which the propriety of "deeming" must be determined. These are problems for the Secretary to consider. Naturally, not every potential situation can be addressed by the Secretary's regulations. But the regulations must apply reasonably to the situations they do address, and must develop general principles applicable to different situations as they arise.

D

Congress has stated that it is the primary responsibility of the Secretary, and not the courts, to determine whether and to what extent "deeming" is to be permitted from an individual to his or her institutionalized spouse. Such determination, however, must proceed within the framework established by the Medicaid statute. It is our duty to ensure that this occurs. The record in this case reflects that HHS regulations permit "deeming" in 209(b) jurisdictions because the Secretary thought that internal consistency within the Medicaid statute required such permission, and that Congress has specifically approved the practice. We disagree. To the contrary, in issuing regulations implementing the 209(b) option the Secretary is required to consider those policy concerns, outlined in part above, which Congress intended would guide her discretion in determining under what circumstances, and to what extent, "deeming" would be permitted.[15]

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[15] Using an approach similar to that taken in this case, the First Circuit in *Kollett v. Harris*, 619 F.2d 134 (1980), upheld HEW regulations under which SSI cash payments to disabled children are reduced by a "deemed" amount. The court recognized as applicable the *Overton Park* requirement that the regulations be the product of a consideration of the relevant factors. This requirement was met in *Kollett* because the Secretary "gave sufficient attention to a wide range of issues including the general type of matters mentioned by the district court [to be relevant]." 619 F.2d at 141. We are confident that the "deeming" regulations challenged in this case would not pass a comparable test. Accordingly, we have no occasion to comment on the relatively forgiving interpretation of *Overton Park* employed in *Kollett*.

III

The District Court's order vacating the subject regulations is affirmed. The case is remanded to the District Court with direction to remand it to the Secretary for promulgation without delay of new regulations consistent with the Medicaid statute as interpreted in this opinion.

So ordered.

MACKINNON, *Circuit Judge*, concurring in part and dissenting in part.

In my view we should uphold the "deeming" practice involved in this appeal, and the basis of my disagreement with the majority's approach on this point is set forth below.

"Deeming" is the use of a formula to make a determination of the income available to support an institutionalized spouse, or, as defined by the district court, the "imputing of income on the basis of an arbitrary formula, without regard to the amount actually available to the institutionalized spouse . . ." *Gray Panthers* v. *Secretary, Department of Health, Education and Welfare*, 461 F. Supp. 319, 321 (D.D.C. 1978). As with any formula the approach may result in hardship in cases where it imperfectly reflects the financial condition of the married couple involved. At the same time, "deeming" is a rational and necessary method of making a determination of available support and assessing financial responsibility in a program like Medicaid which involves hundreds of thousands of people, millions of dollars, *Herweg* v. *Ray*, ___ F.2d ___, No. 78-1664 (8th Cir. March 18, 1980); *Norman* v. *St. Clair*, 610 F.2d 1228, 1242-3 (5th Cir. 1980), and allocates limited resources. *Dandridge* v. *Williams*, 397 U.S. 471, 478-79 (1969). *See also Weinberger* v. *Salfi*, 422 U.S. 749 (1975).

My disagreement with the majority opinion centers upon its failure to accord unequivocal approval to "deeming" as prescribed in the regulations of the agency. While the majority opinion approves the "deeming" regulations conceptually, they are nevertheless remanded to the Sec-

retary for reconsideration in light of a series of ambiguous factors delineated in the majority's opinion. Slip Op. at 10–11. This court should resolve this case as it is presented; a remand is not necessary for the resolution of issues involved in this appeal.

The majority should recognize that the scope of our review is severely circumscribed. The Secretary's regulations should be set aside only if they are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. §§ 706(2)(A), (C). *See Batterton* v. *Francis*, 432 U.S. 416, 426 (1977). The majority opinion acknowledges that both "SSI States" and "209(b) States"[1] are governed by the same requirement, i.e., that only "available" income be considered in determining eligibility for Medicaid benefits. However, in the SSI States, income is deemed by statute to accrue to an institutionalized spouse for a period of six months. 42 U.S.C. § 1382c(b) The Secretary identifies this provision as authority for "deeming" in 209(b) States. The majority deals with this proposal by stating that

> "[i]t is enough to say that there is no required federal statutory 'deeming' in the 209(b) jurisdictions which are the subject of this case, and that there is no justification for extending the anti-fraud six-month limitation on the general policy beyond its statutory confines."

Slip Op. at 7 (footnote omitted).

One additional factor is useful in identifying the extreme nature of the Gray Panthers' attack. At oral argument the following colloquy occured:

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[1] States participating in the Medicaid program fall into two categories: those which determine eligibility under the Supplemental Security Income program ("SSI") Title XVI of the Social Security Act, 42 U.S.C. § 1381 *et seq.* (1976) and those states which have elected a more restrictive eligibility criteria, an option authorized by Section 209(b) of the 1972 Amendments to the Social Security Act, Pub. L. No. 92-603, 86 Stat. 1484 codified at 42 U.S.C. § 1396a(f). In shorthand fashion, the states exercising this option are referred to as "209(b) States" and others as "SSI States."

Judge MacKinnon: "They're not going back; they're staying with them [the standards in effect in 1972].

* * * * *

Mr. DeFord [counsel for the Gray Panthers]: "Well, my only point is whatever the standards in 1972, if they were impermissible at that time a state should not be allowed to go back to them."

Judge MacKinnon: "What are you talking about, go back to them?"

Mr. DeFord: "Well, a state should not be able to maintain them, then. If they were impermissible in 1972 under the statute as set out in 1965, then the states should not be able to use the 209(b) option to maintain any invalid attribution of income."

Judge MacKinnon: "Well, then your point is they're all invalid. The deeming is all invalid."

Mr. DeFord: "That's correct your Honor . . .".

Later, the court and counsel turned to the question of what effect invalidating the deeming regulations would have administratively:

Judge MacKinnon: "Go through determination, you mean go to hearing?"

Mr. DeFord: "The normal welfare procedure, your Honor, by which a state determines what the income and expenses of the individual are. It is a fairly common procedure."

Judge Wright: "You mean, there would have to be a fact hearing in every case?"

Mr. DeFord: "I'm not talking about a hearing, your Honor. I'm simply talking about the state welfare officials sitting down with the non-institutionalized spouse figuring out what the expenses and income of that individual are."

These colloquies illustrate several important points. First, Gray Panthers is attacking the *concept* of "deeming", not just its application to Medicaid programs in the 209(b) States. Second, Gray Panthers would substitute an individual hearing in every case for "deeming." The extreme nature of these arguments also provides a basis for

their rebuttal. The purpose of "deeming" is not only to mitigate fraud, a ubiquitous and monstrously costly problem in the administration of any assistance program, but also to facilitate the administration of the program itself, thereby reducing the percentage of resources devoted to the administration programs, and increasing the percentage which can be actually distributed to program beneficiaries. *See Brown v. Stanton*, ___ F.2d ___, No. 79-1459 at 18 (January 30, 1980) (Pell, J., concurring in part, and dissenting in part). While counsel for Gray Panthers did not advocate a full dress adversary hearing but an individualized, in-person determination of expenses and income for each couple affected by this program, the fact remains that such a proposal is a limited hearing, albeit termed an informal one and would involve practically all the detriments of a hearing. In administering Social Security benefits, Congress has often elected to use "simple criteria". The Supreme Court has observed that "[g]eneral rules are essential if a fund of this magnitude is to be administered with a modicum of efficiency even though such rules inevitably produce seemingly arbitrary consequences in some individual cases. *Weinberger v. Salfi*, 422 U.S. 749, 776 [1975]." *Califano v. Jobst*, 434 U.S. 47, 53 (1977). Nothing in the statute suggests that Congress intended to deny the states recourse to similar efficiencies. Nothing in the statute suggests that Congress intended to burden participating states with the layers of administrative structure.

The approach taken by the majority falls well short of that advocated by the Gray Panthers. But the soft direction provided by the court will not provide meaningful guidance for the Secretary to reevaluate her regulations. Indeed, the groundwork has already been laid for a second appeal to measure compliance by the Secretary against the somewhat indefinite benchmarks provided by the majority. We could avoid this recurring review without distorting the statutory scheme by affirming the Secretary's regulations.

II

The only villain here is the level of need which has not been adjusted to reflect skyrocketing costs of living. However well-intentioned, the court cannot through a remand to the Secretary affect the inflationary pressures which are particularly burdensome to people on fixed incomes. In a concise concurrence in *Kollett v. Harris*, ___ F.2d ___, No. 79-1453 (1st Cir. April 18, 1980), upholding "deeming" from a parent to a disabled child in determining the amount of cash assistance payments under a Supplemental Security Income program, 42 U.S.C. 1381 *et seq.*, Judge Aldrich aptly addressed the issue of "deeming":

> As one who participated in *Boucher v. Minter*, D.Mass., 1972, 349 F.Supp. 1240, from which plaintiffs would derive much support, I feel I should recite that I am entirely comfortable with its present rejection. The enormous enterprise which social insurance has become would fall of its own weight if practical, rule of thumb guidelines could not be established to avoid piece by piece scrutiny of every case. The Supreme Court having forcefully recognized that this is permissible even though occasional hardship is inevitable, *Weinberger v. Salfi*, 1975, 422 U.S. 749, the principle applies that there must be some reason in fact, or logic, before the agency's judgmental expertise is overruled. On the point here in issue the agency's experience is obviously considerable. I cannot think that it abused its discretion in choosing this rule rather than some other.

Id. at 25.

III

Because in my opinion there is nothing to suggest that the Secretary's action in promulgating the regulations allowing the use of "deeming" in SSI States states is arbitrary or capricious, the limit of our scope of review, I respectfully dissent from that part of the court's opinion which holds to the contrary.

APPENDIX B

In the United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

SEPTEMBER TERM, 1979

No. 79-1334

GRAY PANTHERS

v.

ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL., APPELLANTS

[Filed Sept. 3, 1980]

Before: WRIGHT, *Chief Judge* and BAZELON, *Senior Circuit Judge.*

ORDER

It is ORDERED by the court, *sua sponte*, that the opinion for the court filed July 29, 1980 be, and it is hereby, amended as follows:

Page 1: Change "Health, Education and Welfare" in the listing of counsel to "Health and Human Services"

Page 3: Change "acocrdance" in line 4 of the first full paragraph to "accordance"

Delete "a" in line 8 of the same paragraph

Page 4: Change "precusors to" in the third line from the bottom of text to "precursors of"

Page 8: Change "(1980)" in line 4 to "(8th Cir. 1980)"

Change "(1980)" in line 14 to "(1st Cir. 1980)"

Change "as" in the last line of text to "at"

Page 9: Change "SSS" in line 4 to "SSI"

Page 10: Change "(1980)" in the last line of text to "(5th Cir. 1980)"

Page 14: Change "(1980)" in line 2 of footnote 15 to "(1st Cir 1980)"

Per Curiam
For the Court

George A. Fischer
/s/ ROBERT A. BONNER
By: Robert A. Bonner
Chief Deputy Clerk

APPENDIX C

In the United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

SEPTEMBER TERM, 1979

No. 79-1334

GRAY PANTHERS

v.

ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

[Filed Aug. 12, 1980]

Before: WRIGHT and MACKINNON, *Circuit Judges*, and MARKEY, *Chief Judge*, United States Court of Customs and Patent Appeals

ORDER

It is ORDERED by the Court, *sua sponte*, that the dissenting opinion in the above captioned case, filed herein July 29, 1980, be and hereby is, amended as follows:

On page 6, line 3, strike "SSI States states" and insert "209(b) States".

Per Curiam
For the Court

/s/ George A. Fisher

GEORGE A. FISHER
Clerk

APPENDIX D

In the United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

SEPTEMBER TERM, 1979

Civil 78-0661

No. 79-1334

GRAY PANTHERS

v.

ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL., APPELLANTS

[Filed July 29, 1980]

Appeal from the United States District Court for the District of Columbia.

Before: WRIGHT, *Chief Judge*, MACKINNON, *Circuit Judge*, and MARKEY*, *Chief Judge*, United States Court of Customs and Patent Appeals

JUDGMENT

This cause came on to be heard on the record on appeal from the United States District Court for the District of Columbia, and was argued by counsel.

On consideration thereof It is ordered and adjudged by this Court that the judgment of the District Court appealed from in this cause is hereby affirmed and the case is remanded to the District Court with directions to remand

*Sitting by designation pursuant to 28 U.S.C. § 293(a)

it to the Secretary for reconsideration, consistent with the opinion of this Court filed herein this date.

Per Curiam
For the Court

/s/ _____
GEORGE A. FISHER
Clerk

Date July 29, 1980

Opinion for the Court filed by Chief Judge Wright.

Opinion concurring in part and dissenting in part filed by Circuit Judge MacKinnon

APPENDIX E

UNITED STATES DISTRICT COURT
DISTRICT OF COLUMBIA

GRAY PANTHERS, PLAINTIFF,

v.

SECRETARY, DEPARTMENT OF HEALTH, EDUCATION AND WELFARE ET AL., DEFENDANTS.

Civ. A. No. 78-0661.

Dec. 8, 1978.

MEMORANDUM OPINION

CHARLES R. RICHEY, *District Judge.*

This case is before the Court on cross motions for summary judgment.[1] The basic issue in this case is whether regulations[2] promulgated by the defendants, which allow states to "deem" income from a non-institutionalized spouse available to an institutionalized spouse, are inconsistent with the requirements of the Medicaid statute, in particular 42 U.S.C. § 1396a(a)(17). The Court finds there to be no genuine issue of material fact in dispute and, for

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[1] Plaintiff initially filed a motion for partial summary judgment which sought judgment only as to the statutory claim. However, in its reply to defendants' motion for summary judgment, the plaintiff expanded its initial motion to one for summary judgment on all claims. *See* Plaintiff's Reply Memorandum at 1 n.1) (October 13, 1978).

[2] New regulations were made final since the motions were filed. The parties, however, have stipulated that these new regulations (42 C.F.R. §§ 435.734, 436.602 and 436.711) have the same effect as the prior regulations (42 C.F.R. §§ 448.3(b)(1), (4), and 448.21(a)(2). *See* Stipulation (November 22, 1978). To be consistent with the papers in this case, the Court's Memorandum Opinion and Order will use the former regulations—but the parties should consider references to the prior regulations to be references to the appropriate present ones.

the reasons hereinafter stated, will grant summary judgment to the plaintiff on its statutory claim for relief.

I. BACKGROUND

Plaintiff, Gray Panthers seeks in this action to invalidate as inconsistent with the Medicaid statute regulations promulgated by the defendants which allow certain states to "deem" available to an institutionalized spouse income from the noninstitutionalized spouse.

Medicaid is a cooperative federal-state program established pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.* In accordance with the Act, the Secretary of Health, Education and Welfare promulgates regulations, through the Administrator of the Health Care Financing Administration, which supplement the statutes in providing the framework in which participating states must develop and operate their Medicaid programs. States are not required to institute a Medicaid program, but if they choose to do so, they must submit to the Secretary of HEW a satisfactory "state plan" which fulfills all requirements of the Act. 42 U.S.C. § 1396a. The state plan describes the nature and scope of the state's Medicaid program and provides assurances that the state will administer its program in conformity with the requirements of the federal statute, regulations, and other applicable official issuances of the Department. 45 C.F.R. § 201.2. If the state submits a plan which fulfills all the requirements of the Act, the Secretary must approve it. 42 U.S.C. § 1396a(b). The state thereupon becomes entitled to grants of federal funds in reimbursement of a portion of the expenditures which it makes in providing specific types of medical assistance to eligible individuals under the plan in accordance with the federal conditions. 42 U.S.C. § 1396b; 45 C.F.R. § 201.5.

Section 1902 of the Social Security Act, 42 U.S.C. § 1396a, provides, in pertinent part:

(a) A state plan for medical assistance must—

* * * * *

> (17) include reasonable standards. . . for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient . . ., (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child.

Prior to April 13, 1977, all participating states were subject to the same controlling federal regulations. Section 248.3 of Title 45 of the Code of Federal Regulations stated that, with respect to the categorically needy and the medically needy (if included in the state plan), a state plan must "provide that only such income and resources as are *actually available* will be considered and the income and resources will be reasonably evaluated." (emphasis added). On the basis of section 1902(a) of the Act and these regulations states were expected to evaluate the eligibility of individuals applying for Medicaid who required institutionalization and whose spouses continued to live in the couple's home. Despite the requirement that only "available income" should be considered, states considered an arbitrary portion of the income of non-institutionalized spouses available for the care of institutionalized spouses whether in fact that income was available and whether the noninstitutionalized spouse was actually able to make such an amount available. This inputing of income on the basis of an arbitrary formula, without regard to the amount actually available to the institutionalized spouse, is commonly referred to as "deeming."

New regulations were promulgated and finalized, effective April 13, 1977. The introductory language of the regulations read, in part:

> (b) With respect to both the categorically needy and, if they are included in the plan, the medically needy, a State plan must:

> (1) *General.* Provide that only such income and resources as are considered available under the provisions of this section may be considered as an applicant's or recipient's income in determining eligibility or the amount of assistance and that income and resources will be reasonably evaluated.

42 C.F.R. § 448.3. The effect of this new introductory language is the imposition of different requirements amongst the various jurisdictions. The thirty-four states and the District of Columbia which automatically provide Medicaid assistance to recipients of Supplementary Security Income ["SSI"] are now specifically required to use the SSI rules on availability of income. 42 Fed.Reg. 2685. When Congress initially created SSI, it intended to require that all states provide Medicaid assistance automatically to all SSI recipients. Because this would have resulted in a huge increase in the Medicaid rolls in the various states, and Congress feared that some states might opt out of the Medicaid program altogether, Congress added a provision which gave states the option of utilizing more restrictive eligibility conditions. Under this provision, section 1902(f) of the Act, 42 U.S.C. § 1396a(f), a state was permitted to use any financial eligibility condition which was no more restrictive than that in use under the state's January 1972 eligibility conditions for its categorical programs. Therefore, those states which elect this option may deem income available from noninstitutionalized spouses which may not in fact be available. At present, fifteen states have chosen the optional basis for determining Medicaid eligibility provided by 42 U.S.C. § 1396a(f).

In its complaint, plaintiff raises three claims for relief. First, plaintiff claims that the "deeming" of income from a noninstitutionalized spouse to an institutionalized Medicaid recipient is in violation of 42 U.S.C. § 1396a (a)(17), and is, therefore, void. Second, plaintiff contends that the "deeming" of income creates an irrebuttable presumption which violates the due process clause of the fifth amendment. Third, plaintiff contends that the deeming of

income violates the equal protection component of the due process clause of the fifth amendment.[3]

II. DISCUSSION

The issue presented for resolution is whether the deeming of income between spouses separated by institutionalization, permitted by 42 C.F.R. §§ 448.3(b), 448.21(a)(2) violates the requirements of 42 U.S.C. § 1396a(a)(17) of the Medicaid statute. The Court, after careful consideration of the extensive memoranda filed and the relevant authorities, finds that deeming is inconsistent with the statute.[4] This conclusion is based on the language of the statute, its legislative history and case law interpreting it.

As noted above, 42 U.S.C. § 1396a(a)(17) provides, in pertinent part, that a state plan for medical assistance must include reasonable standards for determining eligibility which

> (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient . . . , (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or

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[3] Because of the Court's resolution of the statutory issue, the Court need not and should not reach the constitutional issues raised by the plaintiff. *See Rosado* v. *Wyman*, 397 U.S. 397, 402, 90 S. Ct. 1207, 25 L. Ed.2d 442 (1970); *King* v. *Smith*, 392 U.S. 309, 88 S. Ct. 2128, 20 L.Ed.2d 1118 (1968).

[4] Although defendants have raised an objection to plaintiff's standing to bring this action, the Court finds, upon review of the affidavits and complaint, that plaintiff has standing because its members would have standing to sue in their own right. *See Hunt* v. *Washington Apple Advertising Co.*, 432 U.S. 333, 343, 97 S. Ct. 2434, 53 L.Ed.2d 383 (1977); Affidavits of Smith (September 5, 1978), Sandifer (September 5, 1978), Goldfarb (November 7, 1978), and Pittman (November 12, 1978).

> recipient is such individual's spouse or such individual's child. . . .

The statute clearly states that only such income and resources as are "available to the applicant" may be taken into account. The phrase "as determined in accordance with standards prescribed by the Secretary" allows the Secretary to prescribe broad standards for determining what is "available;" however, this phrase does not allow the Secretary to determine in a wholesale fashion what *should* be available to the applicant.[5] This interpretation is clear from the legislative history of the statute.

The Senate Finance Committee, which prepared the report on the Medicaid statute, states:

> Another provision is included that requires States to take into account only such income and resources as (*determined in accordance with standards prescribed by the Secretary*), are *actually available* to the applicant or recipient. . . .

S.Rep. No. 404, 89th Cong., 1st Sess. 78, *reprinted in* [1965] U.S. Code Cong. & Admin. News, pp. 1943, 2018 (emphasis added). Thus, it is clear that the phrase "determined in accordance with standards prescribed by the Secretary" in subpart (B) was not intended to remove the requirement that only "actually available" income and resources would be considered.

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[5] Subpart (D) of the statute is not to the contrary. That subpart merely prohibits a state from taking into account the "financial responsibility" of anyone except spouses and parents. While it may allow a state to enforce its financial responsibility laws against a spouse or parent, this subpart does *not* suggest that the amount of contribution from that person should be a deemed amount. In fact, this is exactly what Congress had intended subpart (D) to mean.

> The committee believes it is proper to expect spouses to support each other and parents to be held accountable for the support of their minor children and their blind or permanently and totally disabled children even though 21 years of age or older. Such requirements for support may reasonably include the payment *by such relative, if able,* for medical care.

S. Rep. No. 404, 89th Cong., 1st Sess. 78, *reprinted in* [1965] U.S. Code Cong. & Admin. News, pp. 1943, 2018 (emphasis added).

If there were any doubt as to whether deeming violates the Medicaid statute, such doubt evaporates when the purpose of 42 U.S.C. § 1396a(a)(17) is considered. According to the Finance Committee,

> [t]hese provisions are designed so that the States will not assume the availability of income *which may not, in fact, be available. . .*

S.Rep. No. 404, *supra* (emphasis added). By applying an arbitrary formula, unrelated to the expenses of a particular couple's needs, deeming may well result in states "assum[ing] the availability of income which may not, in fact, be available." This would, therefore, be directly contrary to the purpose of the statute.

Thus far, every court that has been confronted with the validity of the deeming procedure has found it to be in violation of the Medicaid statute. In *Herweg* v. *Ray*, 443 F. Supp. 1315, 1319 (S.D. Iowa 1978), the court noted:

> This Court joins other courts in holding that state procedures which "deem" a computed portion of a spouse's income to be available for an institutionalized spouse's expenses by the application of an arbitrary formula are contrary to 42 U.S.C. § 1396a(a)(17) as shown by its language and the expressed Congressional intent.
>
> * * * * *
>
> In the Court's opinion, the state procedure must provide for a factual determination in each instance of the amount of the spouse's income which is in fact reasonably available for the support of the institutionalized spouse. Otherwise the procedures will be in conflict with 42 U.S.C. § 1396a(a)(17). Such determination must give due consideration to the individual obligations and the particular needs of each spouse and family.

See Norman v. *St. Clair*, No. 77-1722 (5th Cir. April 11, 1977) (Order of Judge Ainsworth granting injunction pending appeal to a couple challenging the deeming procedure); *Manfredi* v. *Maher*, 435 F. Supp. 1106, 1114 (D. Conn. 1977) ("It was Congress' intent, as reflected in the legislative history . . . , that spouses be obliged to support

each other only 'if able.' U.S. Code Cong. & Admin. News 1943, 2018 (1965)."[6]) Moreover, in *Burns* v. *Vowell*, 424 F. Supp. 1135 (S.D. Texas 1976), the court scrutinized the legislative history of 42 U.S.C. § 1396a(a)(17) and concluded that

> deeming is never a proper procedure within the requirements for the establishment of means for reasonably evaluating financial responsibility of non-institutionalized spouses . . . [T]he income of a non-institutionalized spouse can [only] be considered . . . through the application of reasonable standards and not on the basis of an irrebuttable presumption that the money is available for the care and support of the institutionalized spouse. Deeming . . . is not consistent with the federal statutes and regulations, and cannot be employed to impute income.

424 F. Supp. at 1140–41. Accordingly, this Court is convinced that the deeming procedure violates the Medicaid statute, and, therefore, is invalid.

III. CONCLUSION

The Court has carefully analyzed the language of the statute, its legislative history, and the pertinent case law. All unequivocally indicate that the deeming procedure—42 C.F.R. §§ 448.3(b)(1), (4); 448.21(a)(2)—is inconsistent with the requirements of the Medicaid statute, 42 U.S.C. § 1396a(a)(17).

An Order in accordance with the foregoing will be issued of even date herewith.

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[6] The court in *Franssen* v. *Juras*, 406 F. Supp. 1375 (D. Or. 1975) appears to also have found deeming invalid. While there is some language in the opinion which may suggest that the presence of a relative responsibility law is determinative, the court expressly noted that the state must "reasonably evaluat[e] the income and resources actually available . . . [and] impose responsibility conform[ing] to federal law." 406 F. Supp. 1379. *See Burns* v. *Vowell*, 424 F. Supp. 1135, 1140–41 (S.D. Texas 1976).

APPENDIX F

United States District Court

FOR THE DISTRICT OF COLUMBIA

C.A. No. 78-0661

GRAY PANTHERS, PLAINTIFF

v.

SECRETARY, DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, ET AL., DEFENDANTS.

[Filed Dec. 8, 1978]

ORDER

Upon consideration of the cross motions for summary judgment, the memoranda filed in support thereof and in opposition thereto, the entire record herein, and in accordance with the Memorandum Opinion issued of even date herewith, and it appearing to the Court that there exist no genuine issues of material fact in this case, it is, by the Court, this 8th day of December, 1978,

ORDERED, that plaintiff's motion for summary judgment be, and the same hereby is, granted, as to Count 1 of the complaint; and it is

FURTHER ORDERED, that defendants' motion for summary judgment be, and the same hereby is, denied; and it is

FURTHER ORDERED, that defendants' regulations, codified at 42 C.F.R. §§ 448.3(b)(1), (4), 448.21(a)(2), are in violation of the Social Security Act; and it is

FURTHER ORDERED, that defendants, their successors in office, agents, employees, and all persons acting in concert with them, are enjoined to rescind the offending regulations, 42 C.F.R. §§ 448.3(b)(1), (4), 448.21(a)(2), to

require all relevant jurisdictions to cease the deeming of income for any length of time between institutionalized Medicaid recipients or applicants and their noninstitutionalized spouses, and to promptly propose and publish new regulations which will conform with the statute; and it is

FURTHER ORDERED, that, with respect to Counts II and III, dealing with the claims of constitutional infirmities raised by the plaintiff, the Court will dismiss these claims, without prejudice, in accordance with the Memorandum Opinion of even date herewith, because, in light of the nature of the Court's ruling, it is unnecessary to reach such constitutional issues; and it is

FURTHER ORDERED, that judgment shall be entered in favor of the plaintiff with costs to be assessed against defendants.

/s/ Charles R. Richey

CHARLES R. RICHEY
United States District Judge

APPENDIX G

United States District Court

FOR THE DISTRICT OF COLUMBIA

C.A. No. 78-0661

GRAY PANTHERS, PLAINTIFF,

v.

ADMINISTRATOR, HEALTH CARE FINANCING AND ADMINISTRATION, ETC., AND SECRETARY, DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, ETC., DEFENDANTS

[Filed Jan. 3, 1979]

ORDER

Upon consideration of defendants' motion to amend order and judgment pursuant to Rule 59(e) of the Federal Rules of Civil Procedure, and the memoranda of the parties in support thereof and in partial opposition thereto, together with all pleadings and memoranda filed in this action, it is, by the Court, this 3rd day of January, 1979,

ORDERED, that the third and fourth paragraphs of the Court's order in this action issued on December 8, 1978, are amended to read as follows:

> "FURTHER ORDERED, that defendants' regulations, formerly codified at 42 C.F.R. §§ 448.3(b)(1)(4), 448.21(a)(2), and now codified at 42 C.F.R. §§ 435.734, 436.602, 436.711 and 436.821, are in violation of the Social Security Act; and it is
>
> "FURTHER ORDERED, that defendants, their successors in office, agents, employees, and all persons acting in concert with them are enjoined to rescind the offending regulations, 42 C.F.R. §§ 435.734, 436.602, 436.711, 436.821, to require all relevant

jurisdictions to cease deeming of income for any length of time between institutionalized Medicaid recipients or applicants and their noninstitutionalized spouses, and to promptly propose and publish new regulations which will conform to the statute; and it is";

and it is

FURTHER ORDERED, that an additional paragraph be added which states:

"The effect of this Order is restricted to states which exercise their option under § 1902(f) of the Social Security Act, 42 U.S.C. § 1396a(f) and the jurisdictions of Guam, Puerto Rico and the Virgin Islands."

/s/ Charles R. Richey

CHARLES R. RICHEY
United States District Judge

APPENDIX H

STATUTORY PROVISIONS AND REGULATIONS INVOLVED

1. 42 U.S.C. 1396a(a) provides in pertinent part:

A state plan for medical assistance must—

* * * * *

(17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient * * * in determining his eligibility for such aid, assistance or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the

Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law;

* * * * *

2. 42 U.S.C. 1396a(f) provides in pertinent part:

Notwithstanding any other provision of this subchapter, * * * no State not eligible to participate in the State plan program established under subchapter XVI of this chapter shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of subchapter XVI of this chapter) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this subchapter and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1396b(f) of this title (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual, and incurred expenses for medical care as recognized under State law) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. * * *

3. 42 C.F.R. 435.734 provides in pertinent part:

In determining medicaid eligibility of an aged, blind, or disabled individual under requirements more restrictive than those used under SSI, the agency must consider the income and resources of spouses * * * as available to the individual in the manner specified in § 435.723 * * * or in a more extensive manner, but not more extensive than the requirements in effect under the medicaid plan on January 1, 1972.

4. 42 C.F.R. 435.723 provides:

(a) If the agency provides medicaid to SSI recipients, it must meet the requirements of this section in

determining eligibility of aged, blind, and disabled individuals under the optional coverage provisions of §§ 435.210, 435.211, and 435.231.

(b) The agency must consider income and resources of spouses living in the same household as available to each other, whether or not they are actually contributed.

(c) If both spouses apply or are eligible as aged, blind, or disabled and cease to live together, the agency must consider their income and resources as available to each other for the first 6 months after the month they cease to live together. After this 6-month period, the agency must consider only the income and resources that are actually contributed by one spouse to the other.

(d) If only one spouse in a couple applies or is eligible and they cease to live together, the agency must consider only the income and resources of the eligible [*sic*] spouse that are actually contributed to the eligible spouse after the month in which they cease to live together.

5. 42 C.F.R. 436.602 provides:

Except for a spouse of an individual or a parent for a child who is under 21 or blind or disabled, the agency must not—

(a) Consider income and resources of any relative available to an individual; nor

(b) Collect reimbursement from any relative for amounts paid by the agency for services provided to an individual.

6. 42 C.F.R. 436.711 provides:

In determining eligibility of individuals specified in subparts B and C of this part who are not recipients of cash assistance, the agency must apply the financial eligibility requirements of the State plan for OAA, AFDC, AB, APTD, or AABD that would be used if the individual were applying for cash assistance. This includes requirements on financial responsibility of spouses and parents, except that, in determining eligibility of families and children, the agency must consider parental income and resources as avail-

able to a child who is living with the parents until he becomes 21, even if State law confers adult status below age 21.

7. 42 C.F.R. 436.821 provides:

In determining eligibility of medically needy individuals, the agency must use the rules for determining whether the income of a spouse or parent is available to the individual that would be used if he were applying for OAA, AFDC, AB, APTD, or AABD. However, for families and children, the agency must consider parental income and resources available to a child who is living with the parent until he becomes 21, even if State law confers adult status below age 21.

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No. 80-756

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ALEXANDER L. STE
CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1980

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, AND ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, PETITIONERS

v.

GRAY PANTHERS

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

JOINT APPENDIX

Petition Filed November 10, 1980
Certiorari Granted January 26, 1981

In the Supreme Court of the United States

OCTOBER TERM, 1980

No. 80-756

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, AND ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, PETITIONERS

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

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The memorandum opinion and judgment orders of the district court (Dec. 8, 1978) and the opinions and judgment of the court of appeals (July 29, 1980) are printed as appendices to the petition for a writ of certiorari (Pet. App. 1a–34a).

1978		
Apr	13	COMPLAINT; appearance.
Apr	13	SUMMONS (4) & copies (4) of complaint issued. U.S. Atty. ser 4-12-78; defts #1 & 2 ser 4-17-78.
Apr	21	ORDER filed 4-18-78 striking the names of the officers of the Executive Branch of the Govt. sued in their individual names & capacities as defts; directing that the case shall proceed against the defts by official title or office only; directing the Clerk of this Court to correct all of its records in this case. (N) (Signed 4-17-78) RICHEY, J.
Apr	27	CERTIFICATE of service by atty for pltf of service of summons & complaint upon Attorney General on 4-17-78; attachment.
June	19	ANSWER of defts to complaint; appearance of Anthony J. Steinmeyer & Rebecca L. Ross.
June	19	CALENDARED. CD/N
July	07	REQUESTS of pltfs for production of documents & interrogatories & requests for admissions; exhibits A-C.
July	27	STATUS CALL: All discovery to be completed by 8-21-78; cross-motions for summary judgment to be filed by 9-8-78; replies to be filed by 9-18-78. (Rep: T. Dourian) RICHEY, J.
July	27	STIPULATION extending time to 8-7-78 for defts to respond to pltfs request for admission & defts time to respond to pltfs interrogatories & requests for production of documents to 8-21-78. Approved. (Fiat) (N) RICHEY, J.
Aug.	07	RESPONSE by defts. to requests for admission.
Sept	08	MOTION of pltfs for partial summary judgment; statement of facts not genuinely at issue; P&A; exhibits A-J.
Sept	08	MOTION of defts for summary judgment; P&A; statement of material facts not in dispute.
Sept	13	MOTION of pltf for enlargement of time on consent for filing reply briefs on cross-motions for summary judgment.
Sept	20	ORDER filed 9-18-78 enlarging time to & including 10-13-78 for submission of reply briefs by all par-

ties; permitting the defts to submit a supplemental reply brief by 10-20-78. (N) RICHEY, J.

1978

Oct. 13 REPLY MEMORANDUM by Pltff.; Table of Contents; Table of Authorities; Exhibit A & B

Oct 13 OPPOSITION by defts. to pltff's [*sic*] motion for partial summary judgment; table of contents; table of authorities.

Oct 23 RESPONSE of defts to pltf's reply memo concerning constitutional issues; table of contents & authorities; exhibit.

Oct 23 RESPONSE of defts to request for production of documents.

Oct 23 RESPONSE of defts to interrogatories; affidavit of Mary S. Kenesson; affidavit of Thomas P. McCormack.

Nov 16 SUPPLEMENTARY exhibits submitted by pltf in support of motion for summary judgment; exhibits (5).

Nov 21 NOTICE of defts of filing; affidavit of John M. Bayne.

Nov 22 STIPULATION with respect to new regulations. Approved. (Fiat) (N) RICHEY, J.

Nov 24 NOTICE by deft of filing; affidavit of Elizabeth J. Barnes.

Dec 12 MEMORANDUM Opinion filed 12-8-78. (N) RICHEY, J.

Dec 12 ORDER filed 12-8-78 granting motion of pltf for summary judgment as to count 1; denying motion of defts for summary judgment; directing that certain regulations are in violation of the Social Security Act; enjoining defts to rescind certain regulations. (N) RICHEY, J.

Dec 13 MOTION of defts to amend order & judgment; P&A.

Dec 22 MEMORANDUM of pltf in partial opposition to motion of defts for amendment of order & judgment.

1979

Jan 05 ORDER filed 1-3-79 amending paragraphs 3 & 4 & adding an additional paragraph to the Court's Order of 12-8-78. (N) RICHEY, J.

Feb 08 MOTION of pltf for order setting schedule for compliance with the Court's previous orders; memo in support of motion; exhibits A-C; affidavit of John H. Foard, attachments (3).

Feb	22	NOTICE of appeal by defts from final judgment entered 12-8-78 & amended 1-3-79. Copy mailed to Toby Edelman. Govt.—no fee.
Feb	22	MOTION of defts for extension of time in which to respond to motion for order setting schedule; P&A.
1979		
Feb	22	MOTION of defts for stay of judgment pending appeal; affidavit of Richard Heim; P&A in support of motion for stay of judgment & in opposition to motion of pltf for order setting schedule.
Mar	05	ORDER filed 2-27-79 extending time to & including 2-22-79 for deft to oppose motion for order setting schedule. (N) RICHEY, J.
Mar	07	CHANGE of address for atty for pltfs. CD/N
Mar	07	MEMORANDUM of pltfs of P&A in opposition to motion of defts for a stay pending appeal & in reply to opposition of defts to motion of pltfs for order setting schedule for compliance with the court's previous order.
Mar	20	MEMORANDUM of defts of P&A in reply to memo of pltf in opposition to motion of defts for a stay pending appeal.
Mar	23	ORDER filed 3-20-79 denying motion of defts for stay & motion of pltf for an order requiring defts to implement Court's previous order & directing defts to submit to the Court a brief report concerning actions taken in implementing Court's order within sixty (60) days. (N) RICHEY, J.
Mar	27	RECORD on appeal delivered to USCA. Receipt acknowledged (79-1334).
May	21	COPY of order from USCA dated 5-18-79 denying motions of appellants for a stay pending appeal & for a temporary stay, except as to that part of the District Court's order of 3-20-79 requiring the appellants to submit to the District Court by 5-21-79 a brief report concerning the actions they have taken to implement the order. The USCA extends that period until 5-29-79.
June	12	MOTION by pltf. for an order requiring defts' full compliance with this Court's Order of 12-08-78 and 1-3-79; P&A; table of contents; table of authorities; exhibit A.
June	22	MEMORANDUM of defts in opposition to motion of pltf for an order requiring defts compliance with

this Court's orders of 12-8-78 & 1-3-79 & response to pltf's accompanying memo.

July 30 ORDER filed 7-26-79 denying motion of pltf requiring full compliance with previous orders of this Court. (Signed 7-25-79) (N) RICHEY, J.

GENERAL DOCKET
UNITED STATES COURT OF APPEALS
FOR THE
DISTRICT OF COLUMBIA CIRCUIT

GRAY PANTHERS

v.

ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, ET AL., APPELLANTS

GENERAL DOCKET
UNITED STATES COURT OF APPEALS
FOR THE
DISTRICT OF COLUMBIA CIRCUIT

DATE	FILINGS—PROCEEDINGS	Filed
(D)3-27-79	Certified Original Record (2 vols.) (n-2)	
(T)4-20-79	4-Appellant's (Federal) motion for stay pending appeal (m-19)	
(T)4-27-79	4-Appellee's motion to extend time to file opposition to appellant's motion for stay pending appeal to May 7, 1979 (m-26)	
(E)5-2-79	Clerk's order granting appellee's motion to extend time to file opposition to motion for stay to May 7, 1979	
(D)5-4-79	4-Appellants' erratum for motion for stay (m-1) (OK RB)	
(C)5-7-79	25-Appellants' brief (m-7)	
(C)5-7-79	4-Appellee's (Gray Panthers) opposition to appellant's motion for stay (m-7)	
(C)5-15-79	Letter dated 5/14/79 from Clerk to Edith S. Marshall, Attorney-at-Law advising that her appearance will be removed from the docket is [*sic*] an application for admission is not received	
(T)5-17-79	4-Appellants' emergency motion for a temporary stay pending a ruling on their motion for stay pending appeal and memorandum in support (m-17)	

DATE	FILINGS—PROCEEDINGS	Filed
(D)5-18-79	4-Appellee's opposition to appellants' emergency motion for a temporary stay pending a ruling on their motion for stay pending appeal and memorandum in support (p-18)	
(E)5-18-79	Per Curiam order denying appellants' motions for a stay and for a temporary stay except as to that part of the District Court's order of March 20, 1979 requiring the appellants to submit to the District Court by May 21, 1979 a brief report concerning the actions they have taken to implement the order. The Court hereby extends that period until May 29, 1979; Fahy, Senior CJ, McGowan, CJ and Robb, CJ (who did not participate)	
(D)5-21-79	4-Appellants' (Federal) response to appellee (Gray Panthers) opposition to appellant' motion for a stay pending appeal (m-17)	
(D)5-24-79	4-Appellants' consent motion to proceed under Rule 30(c), deferred appendix (m-4)	
(C)5-29-79	10-Joint appendix	
(C)5-29-79	4-Exhibits for appendix	
(E)5-31-79	Clerk's order granting the motion to proceed under Rule 30(c)	
(C)6-5-79	15-Appellee's brief (m-5)	
(T)6-22-79	15-Appellants' reply brief (m-22)	
(D)7-30-79	Certified Original Supplemental Record (n-2)	
(D)10-29-79	4-Letter from counsel for appellee advising of additional authorities pursuant to FRAP 28(j) (m-23)	
(C)1-4-80	Letter dated 1/5/80 from Clerk to counsel for appellant advising that a more informative 8(c) certificate is needed within the next 5 days.	
(T)1-4-80	Clerk's order, sua sponte, that the following times are allotted for oral argument Appellant—15 minutes; appellee—15 minutes; only one counsel per side will be allowed to argue	
(C)1-8-80	4-Letter from counsel for appellee in response to Clerk's letter of 1/4/80	
(E)1-15-80	Argued before CJ Wright*, MacKinnon, CJ and CJ Markey, US Court of Customs and Patent Appeals; On motion of Toby Edelman, Gill Deford a member of the bar of the Supreme Court of California was allowed to argue pro hac vice for appellee	

DATE	FILINGS--PROCEEDINGS	Filed
(D)2-6-80	4-Letter from counsel for appellee advising of additional authorities pursuant to Rule 28(j), FRAP (m-5)	
(D)4-11-80	4-Letter from counsel for appellant advising of additional authorities pursuant to Rule 28(j), FRAP (m-11)	
(R)7-29-80	Opinion for the Court filed by Chief Judge Wright	
(R)7-29-80	Opinion concurring in part and dissenting in part filed by Circuit Judge MacKinnon	
(R)7-29-80	Judgment affirmed and the case is remanded to the District Court with direction to remand it to the Secretary for reconsideration, consistent with the opinion of this Court filed herein this date	
(T)08-12-80	4-Appellants' motion to extend time to file a suggestion for rehearing en banc (m-12)	
(H)8-12-80	Ordered by the court that dissenting opinion be amended as follows: (See order).	
(C)08-08-80	4-Appellee's bill of costs (m-5)	
(B)80-25-80	Per Curiam order, sua sponte, that appellants' motion to extend time is granted and the time within which parties may file a suggestion for rehearnig, en banc, is extended to 9-11-80; CJ Wright, MacKinnon, CJ, and CJ Markey, US Court of Customs and Patent Appeals	
(H)9-3-80	Per Curiam order amending opinion of 7/29/80.	
(H)10-1-80	Copy of opinion and certified copy of judgment, 2 amending orders and bill of costs in the amount of $52.16 issued to District Court.	
(T)10-07-80	Receipt dated 10/6/80 from Clerk, District Court for 2 volumes of original record and supplemental record	
(C)10-23-80	Copy of letter from Clerk, Supreme Court extending time to file petition for writ of certiorari to 11/10/81 in SC No. A-336 on 10/20/80	
(T)11-21-80	Notice from Clerk, Supreme Court that a petition for writ of certiorari was filed in SC No. 80-756 on November 10, 1980	
(T)01-28-81	Certified copy of order from Clerk, Supreme Court granting the petition for writ of certiorari in SC No. 80-756 on January 26, 1981	
(T)02-11-81	Clerk's order that the Clerk of this Court shall certify and transmit, as soon as the business of his office	

DATE	FILINGS—PROCEEDINGS	Filed
	permits and without fee, to the Supreme Court of the United States, a record consisting of all documents, including briefs and appendices, filed in this case. The Clerk shall also transmit to the Supreme Court the Certified Original Record and Certified Supplemental Record, filed herein on March 27, 1979 and July 30, 1979, respectively	
(T)02-18-81	2 volumes of original record and supplemental record returned from Clerk, District Court pursuant to order of 2/11/81	

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

[FILED
April 13 1978]

78-0661

GRAY PANTHERS
3700 Chestnut Street
Philadelphia, Pennsylvania 19104
(215) 382-6644, PLAINTIFF,

vs.

ROBERT A. DERZON, ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
P.O. Box 2366
Washington, D.C. 20013
and
JOSEPH CALIFANO, JR., SECRETARY
DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
200 Independence Avenue, S.W.
Washington, D.C. 20201,
DEFENDANTS

COMPLAINT

(For Mandamus, Declaratory and Injunctive Relief)

1. This is an action against the Secretary of the Department of Health, Education, and Welfare (hereinafter "HEW") and the Administrator of the Health Care Financing Administration of the Department, seeking the promulgation and implementation of regulations which would ensure that states participating in the Medical Assistance program (commonly and hereinafter referred to as

"Medicaid") 42 USC § 1396 *et seq.*, are in compliance with the Medicaid statute and the Constitution. The case challenges HEW's policy of implementing regulations which permit some states to deem income available from non-institutionalized spouses to pay for the cost of care of institutionalized Medicaid recipients when in fact that income is not available or is not reasonably available. The policy is in violation of Section 1902(a)(17) of the Social Security Act, 42 USC § 1396a(a)(17), and of the due process clause of the Fifth Amendment to the Constitution.

I. *JURISDICTION*

2. Jurisdiction is conferred on this court by the Mandamus Act, 28 USC § 1361, by 28 USC § 1331, and by the United States Constitution. There is an actual controversy between plaintiffs and defendants, and plaintiffs request a declaration of rights under the Declaratory Judgment Act, 28 USC § 2202.

II. *PARTIES*

3. Plaintiff GRAY PANTHERS is a national organization with headquarters in Philadelphia, Pennsylvania. Its membership is composed of thousands of persons throughout the United States who seek to reform and improve various laws and institutions that affect the lives of our nation's elderly, including health benefit programs such as the federally-sponsored Medicaid program. Approximately two-thirds of the Gray Panthers' membership is composed of individuals who are themselves elderly (65 years of age or older), and the regulations which are here challenged primarily affect elderly Medicaid recipients and their non-institutionalized spouses. Consequently, many members of the Gray Panthers are affected by the procedure here challenged.

4. Defendant JOSEPH CALIFANO, Jr., is Secretary of the Department of Health, Education and Welfare, and as such is charged with the administration of Title XIX of the Social Security Act, 42 USC § 1396 *et seq.*, the Medicaid program. In carrying out this charge, defendant Califano

owes plaintiff a duty to implement regulations which comply with the Medicaid statute and the Fifth Amendment to the Constitution. Defendant is sued in his official capacity and as a representative of all other administrative officers and employees responsible for implementing the Medicaid program.

5. Defendant ROBERT A. DERZON is the Administrator of the Health Care Financing Administration, the arm of the Department of Health, Education and Welfare charged with the promulgation of rules and regulations governing the implementation of Medicaid throughout the country. In carrying out this charge, defendant Derzon owes plaintiff a duty to implement regulations which comply with the Medicaid statute and the Fifth Amendment to the Constitution. Defendant is sued in his official capacity and as a representative of all other administrative officers and employees responsible for implementing the Medicaid program.

III. *STATUTORY AND REGULATORY FRAMEWORK*

6. Medicaid is a cooperative federal-state program established pursuant to Title XIX of the Social Security Act, 42 USC § 1396 *et seq.* In accordance with the Act, the Secretary of Health, Education and Welfare promulgates regulations, through the Administrator of the Health Care Financing Administration, which, in addition to the statutes, provide the framework in which participating states must develop and operate their Medicaid programs.

7. Participating in Medicaid is voluntary with the individual states, but once a state has chosen to participate, it is bound to construct its state-administered Medicaid program within the framework described by statute and federal regulations. At present, forty-nine states, the District of Columbia, and several other jurisdictions participate in the Medicaid program. Only Arizona among the states does not provide Medicaid to its citizens.

8. The federal government pays for at least 50% of each state's Medicaid costs, with the exact percentage dependent on a flexible formula.

9. The states are required to submit state Medicaid plans to HEW for approval. HEW's approval of a state plan ensures the provision of federal matching funds to the state. Without HEW's approval, a state is forced to bear the entire cost of the care which it provides. HEW's approval is in theory dependant on a state plan meeting the guidelines provided by the statute and implementing regulations.

10. Section 1902 of the Social Security Act, 42 USC § 1396a, provides, in pertinent part:

> "(a) A state plan for medical assistance must—
>
> * * * * *
>
> (17) include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient . . . , (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child. . . .

11. Prior to April 13, 1977, all participating states were subject to the same controlling federal regulations. Section 248.3 of Title 45 of the Code of Federal Regulations stated in part:

> "(b) With respect to both the categorically needy and, if they are included in the [State] plan, the medically needy, a State plan must:
>
> (1) Provide that only such income and resources as are actually available will be considered and the income and resources will be reasonably evaluated.
>
> (2) Provide that financial responsibility of any individual for any applicant or recipient of medical assistance will be limited to the responsibility of spouse for

spouse and of parents for children under age 21, or blind, or disabled.

(3) Specify the extent to which the financial responsibility of any such relatives is taken into account."

12. On the basis of section 1902(a) of the Act and these regulations, states were expected to evaluate the eligibility of individuals applying for Medicaid who required institutionalization and whose spouses continued to live in the couple's home.

13. Despite the statutory admonition that only "available" income should be considered, the regulatory requirement that only "actually available" income should be considered, the statute's pronouncement that states should make "reasonable" evaluations of income and resources, and other requirements in the statute and regulations, most states, with the explicit and implicit approval of HEW, considered an arbitrary portion of the income of non-institutionalized spouses available for the care of institutionalized spouses whether in fact that income was available and whether the non-institutionalized spouse was actually able to make such an amount available.

14. This imputing of income on the basis of an arbitrary formula, without regard to the actual needs of the non-institutionalized spouse, is commonly known as "deeming", since the income is deemed available without regard to whether in fact it is available.

15. The effect of this procedure is to place the non-institutionalized spouse in the dilemma of either paying the deemed amount, with the consequent effects on his or her existence, or of not paying it, with the result that the institutionalized spouse will be evicted. The latter result occurs because Medicaid is only paying to the nursing home that portion of the cost of care which is not deemed available for the non-institutionalized spouse.

IV. *THE CHALLENGED REGULATIONS*

16. On December 31, 1975, HEW proposed new regulations on this issue. Their avowed purpose was stated in the preamble to the regulations:

> The proposed regulations is [sic] to ensure that persons who apply for Medicaid as non-cash assistance recipients will have the income and resources of spouses and parents deemed available to them, and considered in determining their financial eligibility, consistent with the provisions of the cash assistance category on which their financial eligibility is based. . . .

40 F.R. 60074 (Dec. 31, 1975).

17. These new regulations were finalized in different form in the Federal Register of January 13, 1977, to be effective three months from that date. 42 F.R. 2684 (Jan. 13, 1977).

18. The introductory language of the regulations now reads, in part:

> (b) With respect to both the categorically needy and, if they are included in the plan, the medically needy, a State plan must:
>
> (1) *General.* Provide that only such income and resources *as are considered available under the provisions of this section* may be considered as an applicant's or recipient's income in determining eligibility or the amount of assistance and that income and resources will be reasonably evaluated.

42 C.F.R. § 448.3 (formerly 45 C.F.R. § 248.3), 42 F.R. 2686 (emphasis added).

19. The effect of this new introductory language is the imposition of different requirements amongst the various jurisdictions. The thirty-four states and the District of Columbia which automatically provide Medicaid assistance to recipients of Supplementary Security Income ("SSI") "are now specifically required to use the SSI rules on availability of income." 42 F.R. 2685. In the other jurisdictions, "those imposing more restrictive criteria under section 1902(f) [of the Social Security Act, 42 USC § 1396a

(f)]," different regulations, theoretically derived from the Medicaid statute, can be utilized.

20. In these latter jurisdictions, the new regulations, by reference to the states' earlier plans, essentially permit the use of the same procedures which were in effect prior to April 13, 1977. The only caveat is that these procedures "not be more restrictive than that included in the State's January 1972 Title XIX [Medicaid] plan." 42 C.F.R. § 448.2(b)(4), (formerly 45 C.F.R. § 248.3(b)(4)). In effect, the new regulations permit these jurisdictions, and any others which may later utilize the option of 42 USC § 1396a(f), to arbitrarily deem income available from non-institutionalized spouses which may not in fact be available and with no limitations as to the length of time that this procedure can be utilized.

21. At present, fifteen states have chosen the optional basis for Medicaid eligibility provided by 42 USC § 1396a(f) and are therefore subject only to the provisions of 42 C.F.R. § 448.3(b)(4). These states are: Colorado, Connecticut, Hawaii, Illinois, Indiana, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, North Carolina, Ohio, Oklahoma, Utah, and Virginia. In addition, Puerto Rico, Guam, and the Virgin Islands use these regulations.

22. Defendants have determined that 42 USC § 1396a(f) allows a state to opt at any time for the use of its more restrictive January, 1972, eligibility guidelines. Some states are either considering or have already taken steps to change the basis of their Medicaid eligibility from SSI to their more restrictive January, 1972, guidelines.

23. At least one of these "SSI states", North Dakota, has already submitted a new state plan to the HEW regional office in Denver, and is therefore eligible to use more restrictive eligibility procedures, including 42 CFR § 448.3(b)(4), prior to approval on the assumption that the plan will be approved, in accordance with 42 CFR § 401.3(g).

V. *IRREPARABLE HARM, INADEQUACY OF REMEDY AT LAW*

24. Defendants' continuing violation of the Constitution and of the Social Security Act is now causing, and, unless restrained by the court, will continue to cause irreparable harm to members of the plaintiff organization. Plaintiff has no adequate remedy at law. The harms which members of the plaintiff organization are suffering and will continue to suffer if defendants are not enjoined from their illegal and unconstitutional acts are not susceptible of redress by an award of money damages.

FIRST CLAIM FOR RELIEF

25. The "deeming" of income from a non-institutionalized spouse to an institutionalized Medicaid recipient is in violation of 42 USC § 1396a(a)(17). Defendants' regulations which permit those jurisdictions using more restrictive guidelines to deem income in contradiction to § 1396a(a)(17) violate the Administrative Procedure Act.

SECOND CLAIM FOR RELIEF

26. The "deeming" of income creates an irrebuttable presumption that a non-institutionalized spouse is capable of paying the amount arbitrarily determined by the state and also assumes that the amount will actually be available for the care of the institutionalized spouse. Such irrebuttable presumptions are in violation of the due process clauses of the Fifth and Fourteenth Amendments.

THIRD CLAIM FOR RELIEF

27. The deeming of income imposes an additional eligibility condition on otherwise eligible Medicaid recipients, thereby creating two classes of recipients. One consists of unmarried institutionalized Medicaid recipients, and the other consists of married institutionalized Medicaid recipients. The discriminatory treatment of the class of married institutionalized Medicaid recipients, whose continued receipt of necessary health care is dependent upon meeting

an additional eligibility condition (the payment of an arbitrary amount by their non-institutionalized spouses), is irrational and capricious, and therefore violates the equal protection component of the due process clause of the Fifth Amendment.

REQUEST FOR RELIEF

WHEREFORE, plaintiff respectfully requests that this Court:

1. Assume jurisdiction over this case.

2. Enter a permanent injunction pursuant to Rule 65, Federal Rules of Civil Procedure, enjoining defendants, their successors in office, agents, employees and all other persons acting in concert with them, from proposing or implementing federal regulations which require or permit states to deem a portion of the income of a non-institutionalized spouse of an institutionalized Medicaid recipient or applicant available without regard to the actual living costs of the non-institutionalized spouse and without regard to whether in fact that amount is made available.

3. Declare that defendants' present regulations on this issue, 42 C.F.R. § 448.3(b), are in violation of the Social Security Act and the due process clause of the Fifth Amendment.

4. Order defendants to rescind the present regulations, to require all relevant jurisdictions to cease deeming of income for any length of time between institutionalized Medicaid recipients and their non-institutionalized spouses, and to promptly propose and publish new regulations which conform with the statute and Constitution.

5. Award plaintiff their costs incurred herein, including reasonable attorneys' fees.

6. Grant such other and further relief as to the Court seems just and proper.

DATED: April 12, 1978

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By _____
STEPHEN ALLEN

By _____
TOBY EDELMAN

Attorneys for Plaintiff

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA
[JUNE 19, 1978]

Civil No. 78-0661

GRAY PANTHERS
3700 Chestnut Street
Philadelphia, Pennsylvania 19104
(215) 382-6644, PLAINTIFF,

v.

ROBERT A. DERZON, ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
P.O. Box 2366
Washington, D.C. 20013
and
JOSEPH CALIFANO, JR., SECRETARY
DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
200 Independent Avenue, S.W.
Washington, D.C. 20201,
DEFENDANTS.

ANSWER

FIRST DEFENSE

Defendants, by their undersigned attorneys, hereby answer the numbered paragraphs of the Complaint as follows:

1. The first and second sentences of this paragraph contain plaintiff's description of its action and not allegations of fact to which an answer is required, but insofar as an answer may be deemed required, deny. Deny the third sentence of this paragraph.

2. This paragraph contains plaintiff's jurisdictional allegations to which no answer is required, but insofar as an answer may be deemed required, deny.

3. Deny for lack of information or knowledge sufficient to form a belief as to the truth of the allegations contained in this paragraph.

4. Admit the first and third sentences. The second sentence contains conclusions of law and not averments of fact to which an answer is required, but insofar as an answer may be deemed required, deny.

5. Admit the first and third sentences. The second sentence contains conclusions of law and not averments of fact to which an answer is required, but insofar as an answer may be deemed required, deny.

6. Admit.

7. Admit.

8. Admit.

9. Admit and aver that HEW's approval is dependent on a state plan meeting the guidelines provided by the statute and implementing regulations.

10. This paragraph contains conclusions of law and not averments of fact to which an answer is required. The Court is respectfully referred to the 42 U.S.C. § 1396a for a full statement of its terms.

11. Deny, except to admit that the quotation from the regulation is accurate and respectfully refer the Court to 45 C.F.R. § 248.3 for a full statement of its terms.

12. Deny, except to admit that section 1902(a) of the Act and the regulations cited are one basis on which states were expected to evaluate the eligibility of individuals applying for Medicaid who required institutionalization and whose spouses continued to live in the couple's home.

13. Deny.

14. Deny except to admit that "deeming" is the appropriate term for the imputing of income from one spouse to another.

15. Deny for lack of knowledge or information sufficient to form a belief as to the truth of these allegations.

16. Admit and respectfully refer the Court to 40 F. Reg. 60074 (Dec. 31, 1975) for a full statement of the terms of the proposed regulations.

17. Admit.

18. Admit and respectfully refer the Court to the regulations for a full statement of their terms.

19. Deny the first sentence. Admit the second and third sentences and aver that the regulations followed by states exercising the 1902(f) (42 U.S.C. § 1396a(f)) option are in fact derived from the Medicaid Statute.

20. Admit the first and second sentence. Deny the third sentence.

21. Deny the first sentence except to admit that presently fifteen states have chosen the optional basis for Medicaid eligibility provided by 42 U.S.C. § 1396a(f). Admit the second and third sentences.

22. Admit.

23. Admit.

24. Deny.

25. Deny.

26. Deny.

27. Deny.

The defendants hereby specifically deny all of the allegations of the complaint not hereinbefore otherwise answered.

SECOND DEFENSE

Plaintiff has failed to state a claim upon which relief can be granted.

Wherefore defendants respectfully request that this action be dismissed.

Respectfully submitted,

/s/ _____
BARBARA ALLEN BABCOCK
Assistant Attorney General

EARL J. SILBERT
United States Attorney

/s/ _____
ANTHONY J. STEINMEYER

/s/ _____
REBECCA L. ROSS

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Tel: (202-739-2230)
Attorneys for Defendants

Of Counsel:

ROBERT P. JAYE
Deputy Assistant General Counsel

EDITH S. MARSHALL
Attorney, Department of Health, Education and Welfare
Washington, D.C. 20201

CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing Answer was served this 15th day of June, 1978 by mailing a copy thereof to

GILL DEFORD, ESQ.
NEAL S. DUDOVITZ, ESQ.
National Senior Citizens Law Center
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Los Angeles, California 90017

STEPHEN ALLEN, ESQ.
TOBY EDELMAN, ESQ.
National Senior Citizens Law Center
1200 Fifteenth Street N.W., Suite 500
Washington, D.C. 20005

/s/ _____
REBECCA L. ROSS

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

[SEPTEMBER 8, 1978]

Civil Action
No. 78-0661

GRAY PANTHERS
3700 Chestnut Street
Philadelphia, Pennsylvania 19104
(215) 382-6644, PLAINTIFF,

v.

ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
P.O. Box 2366
Washington, D.C. 20013
and
SECRETARY
DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
200 Independence Avenue, S.W.
Washington, D.C. 20201, DEFENDANTS.

PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT ON COUNT ONE

Pursuant to Rule 56(a), F.R.Civ.P., plaintiff hereby moves for summary judgment on the first clause of action on the grounds that the complaint raises no genuine issue as to any material fact and that plaintiff is entitled to judgment as a matter of law.

Plaintiff's motion is based on the complaint on file herein, the memorandum of points and authorities filed in support of this motion with accompanying affidavits and exhibits, the responses to requests for admissions and in-

terrogatories and the statement or material facts not genuinely in dispute. The motion is accompanied by a proposed order granting summary judgment to plaintiff.

In accordance with Rule 1-9(f), Local Rules for the United States District Court for the District of Columbia, plaintiff hereby requests an oral hearing on this motion.

DATED: September, 8th 1978.

Respectfully submitted,

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By _____
STEPHEN ALLEN

By _____
TOBY EDELMAN

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

[SEPTEMBER 8, 1978]

Civil No. 78-0661

GRAY PANTHERS, PLAINTIFF,

v.

ADMINISTRATOR,
HEALTH CARE FINANCING ADMINISTRATIONS, ETC., ET AL., DEFENDANTS.

MOTION FOR SUMMARY JUDGMENT

Defendants, Robert A. Derzon, Administrator, Health Care Financing Administration, Department of Health, Education and Welfare and Joseph A. Califano, Jr., Secretary of the Department of Health, Education and Welfare, by their undersigned attorneys, hereby move this Court pursuant to Rule 56 of the Federal Rules of Civil Procedure, for an order entering summary judgment in their favor. The grounds for this Motion are that there are no material facts in dispute and defendants are entitled to judgment as a matter of law.

In support of this Motion the Court is respectfully referred to the Memorandum of Points and Authorities In Support Thereof and the Statement of Material Facts Not In Dispute attached hereto.

Respectfully submitted,

/s/ _____
BARBARA ALLEN BABCOCK
Assistant Attorney General

EARL J. SILBERT
United States Attorney

/s/ _____
ANTHONY J. STEINMEYER

/s/ _____
REBECCA L. ROSS

Attorneys, Department of Justice
Washingon, D.C. 20530
Telephone: 739-2230

Attorneys for Defendants

OF COUNSEL:

ROBERT JAYE
EDITH MARSHALL
Attorneys,
Department of Health, Education, and Welfare
Washington, D.C. 20201

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

[NOVEMBER 22, 1978]

Civil No. 78-0661

GRAY PANTHERS, PLAINTIFF,

v.

ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATIONS, ETC., ET AL., DEFENDANTS.

STIPULATION

The parties, by their undersigned attorneys, hereby stipulate and agree that:

1. Defendants published new regulations governing the medical assistance (Medicaid) program in the Federal Register for Friday, September 29, 1978 (Part V). These appear at 43 Fed. Reg 45176.

2. The new regulations are final, effective October 1, 1978.

3. These regulations are intended to make no change in policy from that of the previous regulations, but to reorganize and rewrite the previous regulations in clearer, simpler language.

4. Former 42 C.F.R. §§ 448.3(b)(1) and (4), which permitted the deeming or imputation of income between spouses separated by institutionalization in the states electing the restricted eligibility option under § 209(b) of P.L. 92-603, have been replaced in part by 42 C.F.R. § 435.734, which has the same effect.

5. Former 42 C.F.R. § 448.21(a)(2), which permitted the deeming or imputation of income between spouses separated by institutionalization in Guam, Puerto Rico and

the Virgin Islands, has been replaced in part by 42 C.F.R. §§ 436.602 and 436.711, which have the same effect.

6. The promulgation of these regulations does not affect the posture of this lawsuit, in the opinion of the parties. In reading the papers submitted in this case the Court is respectfully requested to consider references to the former regulations to include reference to the present regulations.

/s/ _____

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Attorney for Plaintiff

Approved:

/s/ Charles R. Richey

UNITED STATES DISTRICT JUDGE

Date: 11/22/78

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

[AUGUST 7, 1979]

Civil Action No. 78-0661

GRAY PANTHERS, ETC., PLAINTIFF,

v.

SECRETARY OF THE DEPARTMENT OF
HEALTH, EDUCATION AND WELFARE, ETC.,

and

THE ADMINISTRATOR OF HEALTH CARE
FINANCING ADMINISTRATION, ETC., DEFENDANTS.

NOTICE OF FILING

The defendants hereby file for the record of this case the attached copy of a Regional Letter from the Director of the Medicaid Bureau to the Regional Offices of the Department of Health, Education and Welfare. This letter is provided to the Court and the plaintiff pursuant to the representations previously made by the defendants in their memorandum of June 22, 1979 in opposition to plaintiff's motion for an order requiring defendants' full compliance with this Court's Orders of December 8, 1978 and January 3, 1979.

Respectfully submitted,

/s/ _____
EDITH S. MARSHALL
Special Assistant U.S. Attorney

CERTIFICATE OF SERVICE

I hereby certify that service of the foregoing defendants' Notice of Filing has been made upon plaintiff by mailing a copy thereof to counsel for plaintiff, Toby S. Edelman, Esquire, National Senior Citizens Law Center, 1424 16th Street, N.W., Suite 300, Washington, D.C., 20008, and to Gill Deford, Esquire, and Neal Dudovitz, Esquire, National Senior Citizens Law Center, 1636 West 8th Street, Suite 201, Los Angeles, California, 90017, on this 7th day of August, 1979.

/s/ _____

EDITH S. MARSHALL
Special Assistant U.S. Attorney
U.S. Courthouse
Room 3430D
Washington, D.C. 20001

Attachment A 78-0661

[Filed: August 7, 1979
James F. Davey, Clerk]

HCFA
Regional Letter

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Health Care Financing Administration

MEDICAID
Transmittal No.

Originating Component Code DPS

SUBJECT: Deeming of Income in 209(b) States, Guam, Puerto Rico, and the Virgin Islands

This letter provides clarification of HCFA Regional Letter 79-38 issued May 18, 1979, and HCFA Action Transmittal 79-52 issued May 30, 1979. All 209(b) States and the jurisdictions of Guam, Puerto Rico, and the Virgin Islands

are required to cease deeming income between institutionalized applicants *and recipients* and their spouses.

If further information is needed, please contact James Eshelman at (202) 245-0534

DIRECTOR
Medicaid Bureau

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Civil Action No. 78-0661

GRAY PANTHERS, ET AL., PLAINTIFFS,

v.

SECRETARY, DEPARTMENT OF HEALTH
AND HUMAN SERVICES, ET AL., DEFENDANTS.

[Filed: OCTOBER 9, 1980]

ORDER

The Court held a status call on October 8, 1980 to ascertain the Department of Health and Human Services' progress in promulgating regulations that comply with the Court of Appeals' mandate in *Gray Panthers v. Administrator*, No. 79-1334 (July 29, 1980).

Upon consideration of the representations made at the status call and the entire record herein, it is, by the Court, this 8th day of October 1980,

ORDERED that the Secretary of the Department of Health and Human Services issue regulations on the following schedule:

1. The proposed regulations shall be published in the Federal Register no later than October 28, 1980.

2. There shall be a public comment period ending December 1, 1980.

3. The final regulations shall be published in the Federal Register no later than December 11, 1980.

/s/ _____
CHARLES R. RICHEY
United States District Judge

Supreme Court of the United States

No. 80-756

PATRICIA R. HARRIS, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS,

v.

GRAY PANTHERS

ORDER ALLOWING CERTIORARI. FILED JANUARY 26, 1981

The petition herein for a writ of certiorari to the United States Court of Appeals for the District of Columbia Circuit is granted.

☆U.S. GOVERNMENT PRINTING OFFICE: 338917 274

DEC 30 1980
MICHAEL RODAK, JR., CLERK

No. 80-756

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1980

PATRICIA R. HARRIS, SECRETARY OF HEALTH AND HUMAN SERVICES; AND ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION,

Petitioners,

vs.

GRAY PANTHERS,

Respondent.

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

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Attorneys for Respondent

No. 80-756

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1980

PATRICIA R. HARRIS, SECRETARY OF HEALTH AND HUMAN SERVICES; AND ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION,

Petitioners,

vs.

GRAY PANTHERS,

Respondent.

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

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Attorneys for Respondent

QUESTION PRESENTED

Whether the Court of Appeals correctly affirmed the invalidation of certain Medicaid regulations which, in direct contravention of the statute, allowed certain states to consider income available to an institutionalized spouse which, in fact, was not available.

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OPINIONS BELOW

The opinion of the Court of Appeals (App. A, 1a-17a, to Petition), which was not yet reported at the time of the filing of the Petition, is now reported at 629 F.2d 180.

STATEMENT OF THE CASE

A significant omission in defendants' Statement is their failure to describe the background of the regulations which are the subject of this case. Until April 13, 1977, deeming regulations did not distinguish between the 209(b) and SSI states. 45 C.F.R. §248.3(b) (Oct. 1, 1976). These regulations tracked the Medicaid statute, 42 U.S.C. §1396a(a)(17), by providing that "only such income and resources as are actually available will be considered and that income and resources will be reasonably evaluated." 45 C.F.R. §248.3(b)(1) (emphasis supplied). This requirement of actual availability implemented the spirit and words of the legislative history, which described the relevant provision as "designed so that the States will not assume the availability

of income which may not, in fact, be available." S.Rep.No. 404, 89th Cong., 1st Sess. (1965), reprinted in [1965] U.S. Code Cong. & Admin. News, 1943, 2018.[1/] The Senate Finance Committee Report also stated that "[n]o income can be imputed to an individual unless actually available." Id., at 2018.

Pursuant to these legislative directives, HHS[2/] developed guidelines in its 1966 Handbook of Public Assistance Administration to ensure that states only counted income which was actually contributed:

> "Income and resources are realistically evaluated and are not assumed to be available from sources from which payments are not in fact received .... Available income and resources are income and resources which

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1/ See also H.R.Rep.No. 213, 89th Cong., 1st Sess. (1965), at 67.

2/ Although many of the events discussed in this brief involved the Department of Health, Education and Welfare ("HEW"), the predecessor to Health and Human Services, see 20 U.S.C. §3508, the term "HHS" is intended to refer to both.

> are 'in hand' or under the control of the individual ...." Supplement D, §D-4230(4) (emphasis supplied).

From these guidelines were developed the regulations discussed above, which demanded that states only count income available in fact.

From all appearances, these regulations and guidelines required states to make reasonable evaluations of income and resources, and did not permit states to presume the availability of income or resources which were not actually available. In practice, however, many states did not follow these requirements, and HHS implicitly accepted this apparent violation of its own regulations.[3/] Thus, states did employ deeming procedures prior to the changes which were made in the regulations.

3/ Defendants' statement that deeming was undertaken "[w]ith the approval of the Secretary of Health, Education and Welfare," Pet., at 2, must be a reference to this de facto acceptance of the procedure. As plaintiff has noted, the pre-1977 regulations and guidelines explicitly precluded states from assuming income available which was not in fact available.

Nearly two years after the SSI statute went into effect on January 1, 1974, HHS proposed regulations which were intended to distinguish between the 209(b) and SSI states. 40 Fed.Reg. 60074-60075 (1975). The final regulations, which went into effect on April 13, 1977, carried out this distinction. 42 Fed.Reg. 2684 et seq. (1977). Pursuant to these regulations, the SSI states had their deeming policies limited by the restrictions on deeming in the SSI statute, 45 C.F.R. §248.3(b)(2).[4/] HHS devoted virtually all of its discussion of these new regulations to those applicable in the SSI states. But the "new"

4/ According to the comments, states had been subject to these SSI rules because of the relationship between SSI and Medicaid since the beginning of the SSI program. 42 Fed.Reg. 2685. HHS had not attempted, however, to enforce these requirements prior to implementation of the new regulations, so that until that time, SSI states, as well as 209(b) states, were evaluated under the same regulations. See, e.g., Burns v. Vowell, 424 F.Supp. 1135 (S.D.Tex.1976); Franssen v. Juras, 406 F.Supp. 1375 (D.Ore. 1975).

regulations directed at the 209(b) states were also significant, since, for the first time, they did not include the "actually available" language. Instead, those states were told simply that they could use any eligibility criteria, subject to the proviso that "consideration of income and resources may not be more restrictive than that included in the State's January 1972 Title XIX plan." 45 C.F.R. §248.3(b)(4). Since what was in a state plan at that time should have reflected the actually available language of the prior regulations and guidelines, these new regulations did not result in a substantive change. If HHS had been enforcing its previous regulations against deeming, those which were later applicable only to the 209(b) states would have also forced states not to deem.

The next rewording of the regulations[5/] occurred with the rewriting and

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5/ In the interim, a redesignation took place which changed the codification from 45 C.F.R. §248.3(b)(4) to 42 C.F.R. §448.3(b)(4). See 42 Fed.Reg. 52827 (1977). The wording was not altered.

renumbering of many Medicaid regulations, effective October 1, 1978. This alteration resulted in the present regulation applicable to the 209(b) states, but the prologue to the revision specifically stated that it created no substantive or policy changes. 43 Fed.Reg. 45176 (1978). As a result, the present regulatory citation, 42 C.F.R. §435.734, which merely restates the previous requirement that states cannot use more extensive rules than those in effect in January, 1972, represents the direct descendant of the old 45 C.F.R. §248.3(b)(1), which, under any rational interpretation, appeared to prohibit deeming altogether.[6/]

6/ See Gray Panthers v. Secretary, Department of Health, Education, and Welfare, 461 F.Supp. 319, 320 n.2 (D.D.C. 1978) (Pet. App. E, at 23a n.2). For simplicity's sake, plaintiff has only discussed the evolution of the regulations applicable to the 209(b) states. Those applicable to the three island jurisdictions underwent a similar metamorphosis in codification and wording, and now appear at 42 C.F.R. §§436.602, .711, .821. But they also derive, with no substantive change, from regulations requiring actual availability. See 45 C.F.R. §248.21(a)(2)

(cont. p.7)

These regulations were invalidated by the district court in this case, with defendants ordered "to promptly propose and publish new regulations which will conform with the statute." Pet. App. F,

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6/ (cont.)

(Oct. 1, 1976). And defendants stipulated that the "new regulations ... have the same effect as the prior regulations ...." 461 F.Supp., at 320 n.2 (Pet. App. E, at 23a n.2). Plaintiff thus disagrees with defendants' contention that a different analysis should apply to these regulations. Pet., at 5-6 n.8. Since both types of jurisdiction are directly subject to the provisions of 42 U.S.C. §1396a(a)(17), and the regulations from both have been developed without policy changes from identical predecessors, the same arguments apply to both sets of regulations. The only difference is that for the 209(b) states, defendants have available an additional argument, that those states' deeming practices are "protected" by 42 U.S.C. §1396a(f). See Pet., at 13-14; infra, at 34-36. For the remainder of this brief, therefore, plaintiff will only discuss the regulations applicable to the 209(b) states. That discussion, except for rebuttal of the argument premised on 42 U.S.C. §1396a(f), is necessarily applicable to the regulations controlling the island jurisdictions as well.

at 32a.[7/] Defendants' response was the issuance of an "HCFA [Health Care Financing Administration] Regional Letter" to the regional offices instructing them to direct the affected jurisdictions "to cease deeming income for any length of time between aged, blind, or disabled Medicaid applicants, residing in institutions, and their spouses." It further states that an "Action Transmittal" would follow immediately, as that "is the most expeditious way to inform States of the necessary action. The Action Transmittal will be policy, effective until revised regulations are published." Three days

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7/ Another federal court issued a similar order the following year. Allen v. Califano, No. C-78-212 (D.Utah, Aug. 23, 1979), appeal pending No. 79-2167 (10th Cir.). Although further proceedings on the appeal in that case have been stayed by the Tenth Circuit, the order of the district court was not stayed. Indeed, on December 10, 1980, the Tenth Circuit denied the government's motion to stay the district court order. That August, 1979 order is still in effect, contrary to defendants' implication. Pet., at 7 n.9.

later the Action Transmittal was sent to the states, and it restated the order of the Regional Letter.

Other than this recognition of the effect of the district court order, defendants did not, until pressured, take any further action. Their required "prompt publication" of proposed regulations, consistent with Gray Panthers and Allen, did not take place until November 21, 1979. 44 Fed.Reg. 66855. Consistent with the district courts' decisions, these regulations would have prevented states from deeming income:

> "This [proposed] regulation permits considering income, in [209(b) states and the island jurisdictions], as available to an individual who is aged, blind or disabled only to the extent that the income is in fact contributed to the individual by his or her spouse when either the individual or his or her spouse is institutionalized." 44 Fed.Reg. 66856 (emphasis supplied).

Although the decision of the Court of Appeals was not announced until July 29, 1980, more than eight months after the proposed regulations appeared, defendants

still had not published the regulations in final form. Indeed, they were never finalized.

Like the district court, the Court of Appeals admonished defendants to promulgate new regulations "without delay." 629 F.2d, at 187 (Pet. App. A, at 13a). In light of defendants' past failures in this regard, plaintiff obtained an order from the district court requiring the publication of proposed new regulations by October 28, and final regulations by December 11. After failing for the third time to obtain a stay,[8/] defendants published proposed regulations on October 30, 1980. 45 Fed.Reg. 71821. The final regulations appeared in the December 15, 1980 issue of the Federal Register. 45 Fed.Reg. 82254 et seq. As required by the Court of Appeals, these regulations detail

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8/ The district court denied defendants' motion for a stay of its publication order on October 23, 1980. The district court and the Court of Appeals had denied motions to stay the original district court orders on March 20, 1979 and May 18, 1979 respectively.

a required methodology for all of the 209(b) states and island jurisdictions to follow.

REASONS FOR NOT GRANTING THE PETITION

1. The alleged conflicts which defendants urge as their primary argument for granting the petition are either non-existent, negligible, or irrelevant. Overwhelming case authority agrees with plaintiff and the courts below that deeming between institutionalized and non-institutionalized spouses is impermissible under the Medicaid statute.

Including the decision below, there are, as defendants indicate, Pet., at 7, four cases involving deeming procedures presently pending before this Court on petitions for certiorari.[9/] While

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9/ Gray Panthers v. Administrator, Health Care Financing Administration, 629 F.2d 180 (D.C.Cir.1980), pet. for cert. pending sub nom. Harris v. Gray Panthers, No. 80-756 (filed Nov. 10, 1980); Norman v. St. Clair, 610 F.2d 1228 (5th Cir. 1980), pet. for cert. pending sub nom. Harris v. Norman, No. 80-498 (filed Sept. 27, 1980); Herweg v. Ray, 619 F.2d 1265 (cont. p. 12)

defendants contend that each of these "is to some extent irreconcilable with the others," id., at 7, the more appropriate evaluation is that the significant differences in the nature of these cases render any irreconcilability in their results irrelevant.

Initially, the Herweg decision[10/] must be recognized as of a different breed than the other three. Iowa, the state whose policies are challenged in Herweg, is not a 209(b) state. The key

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9/ (cont.)

(8th Cir. 1980), pet. for cert. pending No. 80-60 (filed July 14, 1980); Brown v. Stanton, 617 F.2d 1224 (7th Cir. 1980), pet. for cert. pending No. 79-1690 (filed April 25, 1980).

10/ An equally divided Eighth Circuit, en banc, upheld a district court decision, 443 F.Supp. 1315 (S.D.Iowa 1978), allowing Iowa, an SSI state, to continue to deem despite an apparent conflict with controlling HHS regulations which limit the duration of deeming. The Secretary was not a party to that case, but, upon request of that court, filed an amicus brief supporting the plaintiffs' position. This Court has asked the Solicitor General to submit an amicus brief. 101 S.Ct. 66 (1980).

to the solution of Herweg is thus not 42 U.S.C. §1396a(f), but, rather, 42 U.S.C. §1396a(a)(10).. The former section provides for the 209(b) option; it is the exception to the rule. The rule is set out in §1396a(a)(10), which requires states to provide Medicaid coverage automatically to all aged, blind, and disabled who are eligible for Supplemental Security Income (SSI) benefits. See, e.g., Harris v. McRae, -- U.S. --, 100 S.Ct. 2671, 2680 & n.1 (1980); Caldwell v. Blum, 621 F.2d 491, 497 (2d Cir. 1980), pet. for cert. pending No. 79-2034 (filed June 24, 1980); 42 C.F.R. §435.120.[11/] On the basis of this "SSI-Medicaid link", HHS promulgated the regulations which forced the SSI states to limit deeming to

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11/ HHS discussed this relationship in its comments to the regulations which differentiated between the 209(b) and SSI states: "[42 U.S.C. §1396a(a)(10)(A)] requires all State Medicaid programs (except those imposing more restrictive criteria under [42 U.S.C. §1396a(f)]) to cover as eligible for Medicaid those aged, blind and disabled persons receiving SSI benefits." 42 Fed.Reg. 2685.

one or six months, depending on the eligibility status of the two spouses. The regulations challenged in Herweg, now codified at 42 C.F.R. §435.723(c), (d), merely implement this basic relationship between the two programs. They are not at issue in any of the other three cases pending before this Court, nor in cases before other courts.12/

Indeed, although deeming is the source of the dispute in Herweg, the real issue in that case is a larger one: whether 42 U.S.C. §1396a(a)(10) does require that the SSI states use all of the SSI criteria in their Medicaid determinations. In its regulations, and in the amicus brief filed before the Eighth Circuit, HHS has answered that question affirmatively. The resolution of Herweg, thus, will not affect the result in this

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12/ Those regulations were implicitly upheld in the only other challenge to the deeming practices of an SSI state after the "SSI-type" regulations became applicable. Griswold v. Page, CCH Medicare & Medicaid Guide, ¶28,537 (N.D. Fla. 1977).

or any other pending case, or, indeed, in any conceivable case involving the criteria relevant to 209(b) states. The issue in Herweg is the relationship between the SSI program and Medicaid; that is not the issue in this case, or in Brown or Norman. In short, it is inaccurate to characterize Herweg as irreconcilable with these other decisions. Although deeming is nominally the issue of that case as well, it bears no relationship to the other cases.

The other three cases, Gray Panthers, Brown, and Norman, are related to the limited extent that they analyze the propriety of deeming pursuant to 42 U.S.C. §§1396a(a)(17) and 1396a(f). Brown and Norman are challenges to state practices which, HHS claims, are permitted under the statute. Gray Panthers is a direct attack on the federal regulations themselves. Whatever inconsistencies may exist between Brown and Norman, the nature of Gray Panthers, with its nationwide effect, renders those differences unimportant.

The instant case eliminates any problems created by different opinions from different circuits. Since Gray Panthers is directed at the Secretary and requires her to implement policies in all relevant jurisdictions, it automatically resolves any inconsistencies emanating from other circuits. At present, all of the affected jurisdictions are subject to regulations which explicitly detail the limitations on deeming applicable in those jurisdictions. See 45 Fed.Reg. 82254 et seq. (1980). The federal regulations which these replace and which were at issue in Brown and Norman were invalidated over two years ago. There is thus no need for this Court to intervene in the dispute because consistency among the states is guaranteed by the decision of the Court of Appeals below.

Moreover, and significantly, with one unimportant exception, there is no difference of opinion regarding the impropriety of deeming. A review of these three cases demonstrates this point. The Brown decision notes that there are essentially two major aspects of deeming. The

first is the determination of the amount of income which a spouse should contribute. The second is the evaluation of whether -- regardless of how much the state determines is a proper contribution -- that amount can be assumed, or deemed, available without, in fact, an actual contribution being made.

The Seventh and Fifth Circuits are not in conflict on the first point. They agree that a flexible mechanism for determining the appropriate contribution is required under the statute in order to ensure that the economic situation of the family at home is taken into consideration. Brown v. Stanton, supra, 617 F.2d, at 1228; Norman v. St. Clair, supra, 610 F.2d, at 1242. By affirming the invalidation of the regulations which permitted states to employ arbitrary formulas for determining the amount of the contribution, and by ordering the Secretary to develop new regulations which are based on "relevant factors," the Court of Appeals below has also agreed on this point. Indeed, no court has held to the contrary, as they all recognize that the

use of an arbitrary and inflexible formula violates the reasonability provision of the statute. 42 U.S.C. §1396a(a)(17)(C).

The second issue is whether the statute permits assumptions as to the availability of the spouse's contribution. The Brown court determined that the statute forbade a state from merely assuming that a contribution is made; unless the spouse actually contributes, the state cannot include that amount as income to the institutionalized spouse. 617 F.2d, at 1230-1231.. The Fifth Circuit disagreed. 610 F.2d, at 1237.

The plaintiffs in Norman did not petition on that point because, for all practical purposes, the Fifth Circuit's decision is of no significance. First, Mississippi is not deeming between spouses separated by institutionalization. Instead, it is operating pursuant to the decision of the district court in Mississippi, which precludes the state from consideration of income and resources which are not in fact available, CCH Medicare & Medicaid Guide ¶29,677, at 10,138 (S.D.Miss.1979), and pursuant to

the HHS directives, issued after the Gray Panthers district court decision, which forbid a 209(b) state from deeming. Moreover, Mississippi has already decided to become an SSI state, effective July 1, 1981. See Petition for Writ of Certiorari, at 14, filed in Harris v. Norman, supra. In addition, there can be no precedential effect from the Norman decision. None of the other states in the Fifth Circuit have taken the 209(b) option,[13/] so that the Court of Appeals' conclusion will have no application to other states either.

These factors thus reduce the decision in Norman to an irrelevancy. The decision has no practical significance for Mississippi or any other states. The only important factor for Mississippi, thus, is the invalidation of the deeming regulations in Gray Panthers.

Finally, there is no conflict between the Gray Panthers and Brown decisions. The latter forbids a state from including

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13/ See 45 Fed.Reg. 82255 n.*.

a deemed amount in the income of the institutionalized spouse. 617 F.2d, at 1231. The Court of Appeals below interpreted the statute to enforce a similar requirement on all states. Noting that "the absence of a spouse from the home because of institutionalization differs significantly in two respects from the situation of cohabiting spouses which is at the heart of the congressional expectation of support," 629 F.2d, at 185, the Court delineated two basic principles distinguishing the situation of spouses separated by institutionalization from other contexts. Id., at 185-186. The essence of this analysis is that the "policy concerns" which the Secretary previously failed to consider, id., at 186, demand that deeming not be permitted where the cause of the separation is institutionalization and where the non-institutionalized spouse does not actually support the institutionalized spouse.

The Brown decision is more detailed, as it outlines exactly what the state can and cannot do, depending on the actions

of the non-institutionalized spouse. The Gray Panthers court, though, since it was considering the general framework of the regulations which the Secretary was required to promulgate, could not provide that degree of detail. It is evident, though, that both courts saw the key scenario, that of spouses separated by institutionalization, as establishing a special circumstance, for which the usual assumptions about support could not be made.

The regulations which the Secretary ultimately promulgates pursuant to Gray Panthers must therefore forbid deeming between institutionalized and non-institutionalized spouses. This is the policy now followed by Mississippi. It is also the policy required by the other courts which have considered the issue. Indeed, every other court which has evaluated this issue has reached a conclusion similar to that in Gray Panthers or Brown; the Norman decision stands alone. The Fifth Circuit expressly recognized that its decision was in contrast to that of all other courts which had considered

the issue. 610 F.2d, at 1240 n.16. The Seventh Circuit explicitly cited this substantial trend against deeming. 617 F.2d, at 1228-1230. Moreover, other courts besides those noted in Brown and Norman have reached the same conclusion. Rubin v. Creasy, CCH Medicare & Medicaid Guide, ¶29,678 (S.D.Ohio 1979); Foard v. Gibson, CCH Medicare & Medicaid Guide, ¶29,679 (W.D.N.C.1979); Krygier v. Buscaglia, CCH Medicare & Medicaid Guide, §29,761 (W.D.N.Y.1979); Allen v. Califano, supra.

There is thus no conflict of any significance between the circuits. Moreover, since the Petition was filed, the Secretary appears finally to have fully evaluated the policy behind deeming and to have recognized the burdens which it places on individuals. By contrast, in urging this Court to review this case, the Secretary made the conclusory statement that her position on deeming was supported by policy considerations:

> "The regulations applicable in 209(b) jurisdictions thus are based on the Secretary's sound

> analysis of the pertinent statutory provisions and due regard for the practical and equitable administration of a nationwide social welfare program." Pet., at 14.

In short, the Secretary contended that her former deeming policy represented both the most administratively efficient and the fairest approach.

Her most recent pronouncement on these issues, however, suggests a considerable change in position, and an enlightened recognition of the real problems created by deeming. Her discussion of policy considerations in the comments to the regulations issued in response to the Gray Panthers orders provides this more recent insight:

> "The Secretary believes that one primary minimum requirement relevant to determining the extent of permissible deeming between spouses in [209(b)] States when one spouse is institutionalized is to adopt policies that are in the best interest of program beneficiaries." 45 Fed.Reg. 82256.

She then lists the significant problems caused by deeming: loss of eligibility if

the deemed amount is sufficiently large; forced eviction if the deemed amount is not actually contributed; disastrous economic consequences for the non-institutionalized spouse if the contribution is made; and unfair pressure placed on the institutionalized spouse by employing deeming rather than relative responsibility laws. Id., at 82256. Furthermore, the limitations on deeming required by these regulations "advance the statutory goal of simplicity of administration and efficient operation of the Medicaid program." Id., at 82257.

These comments strongly contrast with those made in her Petition in this case and in previous pleadings, such as the Petition in Harris v. Norman, supra. In formal statements to this Court, the Secretary vigorously defends her prior deeming regulations, which permitted the practice unlimited in both amount and duration, as the best method for effecting the policy goals of efficient administration and fair direction of a social program. Yet, when directed by the Court of Appeals to carefully evaluate and analyze these

policies, see 629 F.2d, at 186 (Pet. App. A, at 12a), she suggests that a mechanism which limits deeming in both amount and duration effects the same goals of efficient administration and fair treatment of beneficiaries. Emanating from these decidedly inconsistent positions is a prior failure by HHS to determine precisely what the real policy concerns are and how those policies can most efficiently and fairly be carried out.

The comments to the new regulations appear to demonstrate that the agency has carefully, and finally, considered the pros and cons of deeming. That last remaining "conflict" then, an internal one within the collective thought process of HHS, has now been resolved as well. The Court of Appeals below has thus not only clarified any existing statutory confusion; in recognition of the explicit Congressional directive that it is the Secretary who must prescribe the proper standards, 629 F.2d, at 183 (Pet. App. A, at 6a), it has also forced HHS to confront various arguments and to make conclusive policy determinations. By her December

15, 1980 comments to the new regulations, the Secretary has recognized the significant features of deeming, and has squarely sided with beneficiaries. That conflict is thus also resolved.

2. The Petition, however, also raises the issue of cost. The implication is that a prohibition against deeming would have a significant impact. Defendants suggest this by citing a $16 billion figure for fiscal 1977 for all Medicaid costs. Pet., at 10. They note that the sixteen 209(b) states account for about one-third of the 23 million people who received Medicaid benefits nationwide in fiscal 1977. Id., at 10. From those figures, they conclude that "the amount of assistance that would be paid to such individuals will be significantly enlarged if the income of their spouses must be ignored." Id., at 11.

It is significant, though, that defendants do not cite any particular figure for the increased cost of a deeming prohibition. The reason for this omission, which leaves the intended impression that

tremendous increases in Medicaid costs to both state and federal governments would occur, is that the additional cost is actually relatively small.[14/] Indeed, HHS has itself declined to attach any significance to additional costs occasioned when deeming is not permitted. When the regulations which went into effect in April, 1977 were proposed, SSI states complained that the limitations on deeming would have a significant cost impact. This was their major concern. 42 Fed.Reg. 2685. HHS found this an unpersuasive argument:

> "The added costs of this policy are considered less burdensome for non-institutionalized spouses and parents who in some States now have their incomes 'deemed' available to recipients

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14/ The increased burden for state governments would be less than half of the total cost, as the reimbursement formula guarantees that no state is responsible for more than 50% of the Medicaid bill. 42 U.S.C. §1396b. Indeed, most pay considerably less. See 44 Fed.Reg. 10553 (1979); HHS Action Transmittal No. 80-75 (Oct., 1980).

> indefinitely without any test of actual availability. In addition, only seven per cent of the Medicaid nursing home population have living spouses, many of whom are themselves already receiving assistance and thus have no 'deemable' income." Id., at 2685.

HHS thus viewed the states' complaint as both improper on policy grounds, in light of the harsh consequences of assuming income available that was not available, and unimpressive on economic grounds, in light of the relatively few people affected by it. Moreover, HHS' view of the cost impact was with respect to the limitation on deeming in SSI states, which include twice the number affected by this litigation. Still, despite its previous lack of concern in an apparently more costly situation, HHS now urges this Court, by citing impressive (but irrelevant) figures, to accept this case because of its allegedly substantial fiscal impact.[15/] In fact, the financial

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15/ Furthermore, in the comments to its new regulations, HHS again downplays the significance of the "fiscal implications". 45 Fed.Reg. 82257.

effect will be relatively inconsequential.

3. Defendants also contend that they are correct on the merits of the case. These arguments were fully briefed and considered below, and defendants offer no explanation for their inclusion at this point. Of course, there are instances in which discussion of the merits is relevant. For instance, the Court may accept a case for review where the lower court "has so far departed from the accepted and usual course of judicial proceedings ... as to call for an exercise of this Court's power of supervision." Rule 17.1(a), Rules of the Supreme Court. That contention would require a discussion of the merits. But defendants do not suggest that any such abnormal deviation has occurred, nor, from any objective viewpoint, could they. As has been previously noted, the decision of the Court of Appeals is consistent with overwhelming case authority on this issue. The Court of Appeals specifically did not usurp the Congressional directive that the Secretary develop appropriate regulations, but, rather, determined that the Secretary had

failed to consider the "relevant factors" and ordered the case remanded to her to develop new regulations after considering those factors. The appellate court did not act precipitously, but with an explicit recognition of the applicable reviewing standard. 629 F.2d, at 183 (Pet. App. A, at 62-72).

While this brief is not the appropriate forum for an extended discussion of the merits, some attention must be focused on the Secretary's repeated contention that 42 U.S.C. §1396a(f) requires the regulations which the Secretary defends: "The regulations merely permit 209(b) states to consider the income of an applicant's spouse to the extent that they would have done so under their 1972 Medicaid plans -- as Congress intended by enacting the 209(b) option." Pet., at 14. In addition, defendants argue that deeming must be permissible in the 209(b) states because it would be inappropriate, under 42 U.S.C. §1396a(f), for those states to have a less restrictive deeming policy than have the SSI states. Id., at 13-14. This analysis, however, ignores

both common sense and the statute's express directives.

First, 42 U.S.C. §1396a(f) does not state that the eligibility conditions which a 209(b) state employs must be more restrictive than those used in SSI states. Rather, it simply says that a state must provide coverage, in a given month, to any statutorily defined aged, blind or disabled individual if that

> "State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this subchapter and in effect on January 1, 1972 been in effect in such month ...." 42 U.S.C. §1396a(f) (Pet. App. H, at 36a).

In short, the state cannot apply more restrictive eligibility conditions now than it did then.

Nothing in that provision, however, sets the SSI eligibility conditions as the most liberal standard that a 209(b) state may employ. Indeed, if it did, those states which have used more liberal

standards would be required to change them.[16/] The requirement of 42 U.S.C. §1396a(f) is, quite simply, that states ensure eligibility to those who were eligible in 1972. Caldwell v. Blum, CCH Medicare & Medicaid Guide, ¶30,774, at 9369-9370 (N.D.N.Y.1980), appeal pending (2d Cir.). There are no other restrictions.

Nor does the legislative history cited by defendants, Pet., at 13, support their contentions. Those reports only restate the statute, and indicate that Congress sought to allow states to avoid increases in Medicaid roles brought about by the generally more liberal SSI eligibility conditions. There is no suggestion, however, that Congress simultaneously intended to limit those eligibility conditions which were more liberal than

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16/ For instance, Minnesota, a 209(b) state, would have had to employ the SSI deeming standards, which are more restrictive than those which that state uses. See Gray Panthers, 629 F.2d, at 183 n.7 (Pet. App. A, at 6a n.7).

the SSI rules. That was not a legislative goal, nor can section 1396a(f) possibly be read to create that requirement.17/

Defendants assert that the six-month rule for the SSI states requires deeming in the 209(b) states. But that provision exists solely because of a requirement in the SSI statute, 42 U.S.C. §1382c(b), which had nothing to do with deeming, and was designed only to deter fraudulent separations. See H.R.Rep. No. 92-231, 92d Cong., 2d Sess., 150 (1971); Gray Panthers, 629 F.2d, at 184 (Pet. App. A, at 8a). It is employed in the SSI states because of the SSI-Medicaid link. 42

17/ Furthermore, defendants are blatantly incorrect in suggesting that Congress did not contemplate that some non-SSI recipients in 209(b) states would be eligible for Medicaid. Pet., at 13. By requiring, as part of the 209(b) option, that these states use a "spenddown" procedure which allowed deductions for medical expenses, Congress was ensuring that many individuals who did not meet the SSI criteria would be eligible. See 42 U.S.C. §1396a(f); 42 C.F.R. §435.732(c), (d). There is no required spenddown in the SSI states. 42 U.S.C. §1396a(a)(10)(A).

U.S.C. §1396a(a)(10)(A). But the contention that those requirements support deeming in the 209(b) states has no support. On its face, section 1396a(f) does not implicate the SSI standards.

Furthermore, defendants' contention that any provision used in 1972 is automatically valid has been regularly rejected. The courts have recognized that the mere failure to challenge an illegal state eligibility condition prior to 1972 could not have the effect of forever insulating that rule from judicial scrutiny. Thus, the Fifth Circuit held:

> "[209(b)] cannot be viewed as an all-purpose 'grandfathering' clause which effectively legitimizes any and every provision appearing in a state plan in 1972. We find no indication that in passing 209(b) Congress intended to authorize otherwise improper procedures. In other words, if, in January, 1972, the state's deeming procedure was impermissible under 42 U.S.C. §1396a(a)(17), it cannot now be made acceptable simply because of §209(b)." Norman v. St. Clair, supra, 610 F.2d, at 1235.

The Court below specifically relied on

this analysis and conclusion. 629 F.2d, at 185 (Pet. App. A, at 9a). District courts in New York and Illinois have expressly reached the same conclusion, Caldwell v. Blum, supra, CCH Medicare & Medicaid Guide, ¶30,774, at 9366-9367; Winter v. Trainor, CCH Medicare & Medicaid Guide, ¶28,151 (N.D.Ill.1977). The latter made this common sense observation as to the necessary interpretation of section 1396a(f):

> "Implicit in 42 U.S.C. §1396a(f) is the concept that any January, 1972 standard which the state might elect to return to in January, 1974, was a valid standard .... [U]pon exercising its option under 42 U.S.C. §1396a(f), [Illinois] could only elect to return to a standard which was in compliance with statutory and regulatory requirements." CCH Medicare & Medicaid Guide, ¶28,151, at 10,599.

This recognition that the 209(b) option cannot operate to provide retroactive validation of otherwise invalid provisions is consistent with decisions in similar situations. See, e.g., Houston W.R.O. v. Chapman, 555 F.2d 1219, 1225 (5th Cir. 1977), rev'd on jur. grounds 99 S.Ct.

1905 (1979); Johnson v. White, 528 F.2d 1228, 1236-1237 (2d Cir. 1975); Roselli v. Affleck, 508 F.2d 1277, 1280 (1st Cir. 1974); Metcalf v. Trainor, 472 F.Supp. 576, 587 (N.D.Ill.1979); Illinois W.R.O. v. Trainor, 438 F.Supp. 269, 279 (N.D.Ill. 1977). The past failure to challenge a provision does not insulate it forever from attack.

Defendants' arguments on the merits have been regularly repudiated. The option was solely an effort to allow some states to avoid cost increases which would have been occasioned by requiring SSI recipients in all states to be covered. But neither the legislative history nor the provision itself suggests that the 209(b) option was an "all-purpose grandfathering clause," nor do they establish the SSI eligibility conditions as the most liberal which a state could employ. The 209(b) option had a simple purpose, to give states reasonable flexibility. Beyond that, it made no restrictive changes in the eligibility requirements of the statute.

CONCLUSION

There is no split in the circuits requiring resolution by this Court. The petition for certiorari should therefore be denied.

DATED: December, 1980.

Respectfully submitted,

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FILED
MAR 20 1981
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No. 80-756

In the Supreme Court of the United States

OCTOBER TERM, 1980

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, AND ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, PETITIONERS

v.

GRAY PANTHERS

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

BRIEF FOR THE PETITIONERS

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QUESTION PRESENTED

Whether regulations of the Secretary of Health and Human Services governing the extent to which certain states that participate in the Medicaid program may consider the income of an applicant's spouse in determining eligibility for and the amount of Medicaid assistance are arbitrary, capricious, or otherwise unlawful.

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In the Supreme Court of the United States

OCTOBER TERM, 1980

No. 80-756

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, AND ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, PETITIONERS

v.

GRAY PANTHERS

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

BRIEF FOR THE PETITIONERS

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-17a) is reported at 629 F.2d 180. The opinion of the district court (Pet. App. 23a-30a) is reported at 461 F. Supp. 319.

JURISDICTION

The judgment of the court of appeals (Pet. App. 21a-22a) was entered on July 29, 1980. On October 20, 1980, the Chief Justice extended the time in which to petition for a writ of certiorari to and including

November 10, 1980. The petition was filed on that date and was granted on January 26, 1981. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTE AND REGULATIONS INVOLVED

Section 1902(a)(17) and (f) of the Medicaid Act, 42 U.S.C. 1396a(a)(17) and (f), the regulations invalidated by the court of appeals (42 C.F.R. 435.734, 436.602, 436.711, and 436.821), and 42 C.F.R. 435.723 are reprinted, in pertinent part, at Pet. App. 35a-38a.

STATEMENT

1. The Medicaid program was established in Title XIX of the Social Security Act, 42 U.S.C. 1396 *et seq.*, "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris* v. *McRae*, No. 79-1268 (June 30, 1980), slip op. 1-2. As adopted in 1965, Title XIX required participating states to provide medical assistance to individuals who received cash assistance under any of the four "categorically needy" assistance programs established in the Social Security Act.[1] Under Section 1902(a)(17) of the Act, 42 U.S.C. 1396a(a)(17), each participat-

[1] Old Age Assistance (OAA), Title I, 42 U.S.C. (1970 ed.) 301 *et seq.*; Aid to Families with Dependent Children (AFDC), Title IV, 42 U.S.C. (1970 ed.) 601 *et seq.*; Aid to the Blind (AB), Title X, 42 U.S.C. (1970 ed.) 1201 *et seq.*; Aid to the Permanently and Totally Disabled (APTD), Title XIV, 42 U.S.C. (1970 ed.) 1351 *et seq.* Participating states could also offer medical assistance to the "medically needy"—*i.e.*, certain individuals whose income was greater than permissible under the categorical assistance plans but inadequate to pay medical expenses. Congress, however, thought it appro-

ing state was required to adopt "reasonable standards * * * for determining eligibility for and the extent of medical assistance," and to take into account "only such income and resources as are * * * available to the applicant or recipient." Furthermore, in response to practices that had been adopted by states administering medical assistance plans established under the predecessor Kerr-Mills program, Congress required states that participated in the Medicaid program to refrain from taking into account "the financial responsibility of any individual for any applicant or recipient of assistance * * * *unless such applicant or recipient is such individual's spouse*" or minor, blind, or disabled child. 42 U.S.C. 1396a(a)(17)(D) (emphasis added).

With the approval of the Secretary of Health, Education, and Welfare (now Health and Human Services), some participating states took the position that it was reasonable to expect an applicant's spouse to help pay the cost of the applicant's medical expenses and, therefore, adopted rules that took into account the income of the spouse in determining Medicaid eligibility and the amount of assistance. These states calculated an amount considered necessary to pay the basic living expenses of the applicant's spouse and "deemed" any income of the spouse in excess of that amount as "available" to the applicant. Consistent with Congress' expressed intent that the medical expenses of the "most needy" be met first under the Medicaid program,[2] the amount considered necessary to pay the

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priate that the medical expenses of the "most needy" be met before extending benefits to the less needy. See, *e.g.*, S. Rep. No. 404, 89th Cong., 1st Sess. 77 (1965).

[2] See, *e.g.*, S. Rep. No. 404, *supra*, at 77, 78-79; H.R. Rep. No. 213, 89th Cong., 1st Sess. 66, 68 (1965).

basic living expenses of the applicant's spouse was generally set near subsistence level (Pet. App. 5a).

In 1972, Congress replaced three of the four categorical assistance programs with a new federal program, Supplemental Security Income for the Aged, Blind, and Disabled (SSI), Title XVI, 42 U.S.C. 1381 *et seq.*[3] From the beginning of the Medicaid program in 1965, participating states were required to provide medical assistance to those individuals receiving benefits under one of the cash assistance programs. Adoption of the SSI program was not intended to affect this traditional linkage. But under the SSI program, the states would no longer control the standards of need for the aged, blind, and disabled. The group of individuals who would be eligible for SSI assistance and, therefore, eligible for Medicaid assistance was in some states significantly larger than the group that was eligible under the prior assistance programs for the aged, blind, and disabled. To avoid forcing states that participated in the Medicaid program to (1) expand their Medicaid assistance obligations involuntarily, (2) withdraw from the Medicaid program, or (3) reduce the level of benefits provided under the Medicaid program, Congress offered the states what has come to be called the "209(b) option," 42 U.S.C. 1396a(f).[4] Each state was given the option

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[3] As its name indicates, the SSI program replaced the categorical assistance plans for the aged, blind, and disabled. The provisions of the old categorical assistance programs remain effective in Puerto Rico, Guam, and the Virgin Islands. See Pub. L. No. 92-603, Title III, Sections 303(a) and (b), 86 Stat. 1484.

[4] The provision was enacted as Section 209(b) of the Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1381.

of providing medical assistance to all recipients of cash assistance under the SSI program or to the more limited group of individuals who were eligible for SSI benefits and who also would have been eligible for assistance under the state Medicaid plan in effect on January 1, 1972 (*ibid.*; Pet. App. 4a-5a).

Under the SSI statute, the income of an applicant's spouse is attributed to the applicant for the purpose of determining eligibility and the amount of assistance.[5] Any state that participates in the Medicaid program but fails to exercise the 209(b) option (an "SSI state") is required to provide medical assistance to all SSI benefit recipients. Because of the relationship between the Medicaid and SSI statutes, and to avoid the unfairness and administrative difficulties involved in permitting SSI states to determine Medicaid eligibility by reference to rules different from those applied in determining SSI eligibility, the Secretary issued regulations requiring SSI states to consider the income of an applicant's spouse in making Medicaid determinations only to the extent required by the SSI statute. 42 C.F.R. 435.700, 435.723.

In addition, the Secretary required 209(b) states to consider the income of an applicant's spouse in determining Medicaid eligibility and the level of bene-

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[5] When the applicant and his spouse live in the same household, the income of both is considered in determining the eligibility of either for SSI benefits. 42 U.S.C. 1382(a)(1), (2), 1382c(b), 1382c(f)(1). When the applicant and his spouse cease to share the same household, the income of the applicant's spouse is no longer considered in determining the applicant's eligibility for SSI benefits, unless the applicant's spouse is an "eligible spouse," as defined in 42 U.S.C. 1382c(b). By definition, no one can remain an "eligible spouse" for more than six months after separation from his spouse. 42 U.S.C. 1382c(b).

fits at least to the extent that it would be considered in an SSI state. 42 C.F.R. 435.734. Section 209(b) of the 1972 amendments, 42 U.S.C. 1396a(f), however, authorizes a state that exercises the 209(b) option to deny Medicaid benefits to any individual who (although eligible for SSI benefits) would not have been eligible for medical assistance under the more restrictive eligibility standards of the state's Medicaid program in effect in January 1972. Therefore, the Secretary's regulations allow Section 209(b) states to consider the income of an applicant's spouse to the extent that they would have done so under their 1972 Medicaid plans. 42 C.F.R. 435.734.

2. Respondent filed suit in the United States District Court for the District of Columbia, challenging the Secretary's regulations governing the extent to which the income of an applicant's spouse could be considered in making Medicaid determinations in 209(b) states, Puerto Rico, Guam, and the Virgin Islands.[6] Respondent argued that these regulations were inconsistent with Section 1902(a)(17) of the Social Security Act, 42 U.S.C. 1396a(a)(17), and the Due Process Clause of the Fifth Amendment (Pet. App. 26a-27a). Finding the statutory contention dispositive, the district court did not reach respondent's constitutional claims (*id.* at 27a n.3). In the district court's view (*id.* at 28a & n.5), Section 1902(a)(17)(D) of the Act, 42 U.S.C. 1396a(a)(17)(D), "may

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[6] 42 C.F.R. 435.734, 436.602, 436.711, 436.821 (Pet. App. 36a-38a); see *id.* at 23a n.2, 33a. Respondent is "a voluntary organization dedicated to improving the treatment accorded our nation's elderly" (*id.* at 2a). The district court found that respondent had standing to challenge the regulations because some of its members would have had standing (*id.* at 27a n.4).

allow a state to enforce its financial responsibility laws against a spouse or parent," but a participating state may not consider any portion of the income of an applicant's spouse to be "available" to an applicant without making an individual determination of the living expenses of the spouse. The court held that the challenged regulations accordingly were invalid and ordered the Secretary to adopt new regulations "requir[ing] all [209(b) jurisdictions, Puerto Rico, Guam, and the Virgin Islands] to cease the deeming of income for any length of time between institutionalized Medicaid recipients or applicants and their noninstitutionalized spouses * * *" (Pet. App. 31a-32a; *id.* at 33a-34a).[7]

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[7] Given its interpretation of Section 1902(a)(17) of the Act, the district court's invalidation of 42 C.F.R. 435.734 is understandable. The basis for the court's invalidation of the regulations applicable in Puerto Rico, Guam, and the Virgin Islands is more difficult to discern. First, 42 C.F.R. 436.602, which is essentially a restatement of Section 1902(a)(17)(D), simply prohibits the consideration of the income of any of the applicant's relatives, except his spouse or (in some circumstances) his parent. Second, 42 C.F.R. 436.711 and 436.821 simply require the relevant Medicaid agencies to apply the financial eligibility requirements that would be applied in determining eligibility under the old categorical assistance plans (see note 1, *supra*), including the extent to which the income of a spouse should be considered. Since Puerto Rico, Guam, and the Virgin Islands are required to provide medical assistance to all categorical assistance recipients (see 42 U.S.C. 1396a(a)(10)(A)) and (except with respect to the "medically needy" and AFDC beneficiaries) are not entitled to federal assistance for providing medical assistance to individuals who are ineligible to receive benefits under the categorical assistance programs, it is difficult to understand how any other rules could be applied. The court of appeals also

A divided panel of the court of appeals affirmed, but on grounds other than those relied on by the district court. The court of appeals rejected (Pet. App. 8a) the Secretary's analysis of the pertinent statutory provisions, asserting that "there is no required federal statutory 'deeming' in the 209(b) jurisdictions which are the subject of this case." The court of appeals acknowledged (*id.* at 9a) that the "legislative history of the Medicaid statute explicitly addresses the question of when 'deeming' is proper" and "establishes a broad principle * * * that 'deeming' is appropriate between spouses * * *," but it found (*id.* at 10a) that the legislative history of the statute also "recognizes exceptions to the general rule, requiring individualized factual determinations of availability to be made." Citing this Court's decision in *Citizens to Preserve Overton Park, Inc.* v. *Volpe*, 401 U.S. 402 (1971), the court of appeals held the regulations invalid because the Secretary, in authorizing deeming in 209(b) states, failed to consider all of the factors and policy concerns the court thought "relevant" (Pet. App. 7a)—including the difference between spouses living together and those separated by virtue of institutionalization. It therefore remanded the case to the district court (*id.* at 13a) "with direction to remand it to the Secretary for promulgation without delay of new regulations consistent with the Medicaid statute as interpreted in this opinion."

Judge MacKinnon concurred in part and dissented in part (Pet. App. 13a-17a). Judge MacKinnon agreed that the Medicaid Act permits participating states to attribute the income of one spouse to the other. In his view, however, "there is nothing to sug-

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failed to distinguish between the regulations applicable in 209(b) jurisdictions and those applicable in Puerto Rico, Guam, and the Virgin Islands.

gest that the Secretary's action in promulgating the regulations allowing the use of 'deeming' in 209(b) States is arbitrary or capricious, [which is] the limit of our scope of review * * *" (*id.* at 17a, 20a).[8]

SUMMARY OF ARGUMENT

The regulations invalidated by the court of appeals were adopted pursuant to the Secretary's express statutory authority to prescribe standards for determining what income is "available" to a Medicaid applicant within the meaning of Section 1902(a)(17)(B) of the Social Security Act, 42 U.S.C. 1396a(a)(17)(B). Since those regulations are fully consistent with the Medicaid Act and cannot reasonably be characterized as arbitrary, capricious, or otherwise unlawful, they are binding on the courts. *Batterton* v. *Francis*, 432 U.S. 416, 425-426 (1977). The court of appeals erred in substituting its judgment for that of the Secretary as to the meaning of the statutory term and the factors relevant to its interpretation.

A. As used in Section 1902(a)(17)(B) of the Act, the term "available" income includes any income that is received by the applicant or by those individuals whom Congress has determined the states may properly expect to help pay the costs of the applicant's medical care. See 42 U.S.C. 1396a(a)(17)(B), (D). Section 1902(a)(17)(D) prohibits participat-

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[8] Pursuant to the district court's order on remand (J.A. 33a), the Secretary published new regulations allowing 209(b) jurisdictions to consider the income of an institutionalized Medicaid applicant's spouse if the income would be considered in determining SSI eligibility. 45 Fed. Reg. 82254 (1980). But 209(b) states may also ignore the income of an institutionalized applicant's spouse even though it would be considered in determining SSI eligibility. *Ibid.*

ing states from considering the income of any of the applicant's relatives as "available" to the applicant, *except that of his spouse* (or, in some circumstances, his parent). 42 U.S.C. 1396a(a)(17)(D). Subject to the Secretary's authority to define what income is "available" for purposes of determining Medicaid eligibility, therefore, participating states may consider the income of an applicant's spouse as "available" to the applicant.

Participating states may take the income of an applicant's spouse into account whether or not they share a common household. The duty of support arises from the marital relationship, not the spouses' particular living arrangements. Section 1902(a)(17)(D) draws no distinction between institutionalized and non-institutionalized spouses, nor is there any suggestion in the voluminous legislative history that Congress intended an exception to "the seemingly unequivocal expectation that spouses should support each other" (Pet. App. 10a) in cases where the spouses are not living together.

The Medicaid program was not intended as an insurance scheme. Rather, it was designed to allow participating states to provide medical assistance for certain categories of individuals who are least able to afford the costs of medical care or private health insurance. Hence, it was not unreasonable for Congress to determine that eligibility for and the extent of Medicaid benefits should depend, in part, on the financial status of the applicant's spouse, nor was it arbitrary or capricious for the Secretary to promulgate regulations implementing that determination.

B. The Secretary's regulations defining the permissible maximum and minimum extent of "deeming" between spouses in 209(b) jurisdictions are based on

a careful analysis of the interlocking provisions of the Medicaid Act and the statute enacting the Supplemental Security Income for the Aged, Blind, and Disabled (SSI) program. Under Section 1902(a)(10)(A) of the Social Security Act, all states that participate in the Medicaid program must provide medical assistance to the recipients of cash benefits under the SSI program. 42 U.S.C. 1396a(a)(10)(A). Section 209(b) of the Social Security Amendments of 1972, however, gives participating states the option of denying Medicaid benefits to any SSI recipient who would not have been eligible for assistance under his state's 1972 Medicaid plan. Participating states that exercise the 209(b) option are therefore partially exempt from the requirements of 42 U.S.C. 1396a(a)(10)(A). All of the other requirements of the Medicaid statute are generally applicable notwithstanding a state's decision to exercise the 209(b) option.

The Secretary acted reasonably in requiring 209(b) states to follow SSI deeming rules in determining Medicaid eligibility and the amount of assistance. If, in SSI states, the term "available" income, as used in 42 U.S.C. 1396a(a)(17)(B), includes the income of an applicant's spouse to the extent required by the SSI statute, then logically the term should be given the same interpretation in 209(b) states. Moreover, unless 209(b) states are required to consider the income of an applicant's spouse at least to the extent that it would be considered in an SSI state or under the SSI statute, the congressional intent underlying the 209(b) option would be wholly frustrated. The 209(b) option was intended solely to permit participating states to *exclude* from coverage individuals who would be eligible under the SSI criteria, and therefore eligible for Medicaid coverage (see 42

U.S.C. 1396a(a)(10)(A)), but who would not have been eligible under the more restrictive standards of their state's 1972 Medicaid plan. Thus, the purpose of the 209(b) option was to avoid imposing expanded Medicaid obligations on participating states as a result of the more liberal SSI eligibility requirements. The option was not intended to permit 209(b) states to receive federal aid for providing medical assistance to individuals who would not be eligible even under the more liberal SSI criteria.

With limited exceptions, participating states may not provide medical assistance under the Medicaid program to individuals who are ineligible for assistance under the SSI program. For example, under Section 1902(a)(10)(C), participating states may provide medical assistance to certain categories of individuals whose income, "as determined in accordance with standards prescribed by the Secretary" (42 U.S.C. 1396a(a)(10)(C)), is greater than permissible under the SSI program but who have incurred medical expenses that eliminate most of that excess income. The state is only entitled to federal aid for providing medical assistance to these individuals if their family income (less any incurred medical expenses, 42 U.S.C. 1396b(f)(2)), "determined, in accordance with standards prescribed by the Secretary" (42 U.S.C. 1396b(f)(1)(B)(i)), is not greater than 133⅓% of the amount payable to a family of the same size under the state's AFDC program.

In all participating states, therefore, the Secretary's responsibility for administering the Medicaid statute requires that he be able to determine whether any of the non-SSI recipients for whom the state provides medical assistance are nevertheless eligible for SSI benefits. Without redetermining the Medicaid

eligibility of every non-SSI recipient covered under every state plan, it is impossible to make this determination. Thus, unless all participating states are required to consider the income of a Medicaid applicant's spouse at least to the extent that the income would be considered in determining SSI eligibility, the Secretary cannot carry out his responsibility under the statute. In those states that participate in the Medicaid program but do not exercise the 209 (b) option, all SSI benefit recipients must be provided with medical assistance. It follows, then, that (1) all participating states must be required to consider the income of an applicant's spouse to the extent that it would be considered in determining SSI eligibility and (2) states that fail to exercise the 209(b) option may not consider the income of an applicant's spouse if it would not be considered in determining SSI eligibility. The Secretary's regulations, 42 C.F.R. 435.723 and 435.734 (Pet. App. 36a-37a), accomplish this result.

In addition, the Secretary's regulations permitting 209(b) states to take the income of an applicant's spouse into account to the extent that they would have done so under their 1972 Medicaid plans are also consistent with the statute. If the eligibility criteria of a 209(b) state's 1972 Medicaid plan are valid, the Secretary has no power under the statute to require the state "to provide medical assistance to any aged, blind, or disabled individual * * * unless such State would be (or would have been) required to provide medical assistance to such individual * * * had its plan for medical assistance approved under this subchapter and in effect on January 1, 1972, been in effect * * *." 42 U.S.C. 1396a(f). Hence, states that in 1972 considered the income of an institutionalized Medicaid applicant's spouse in making eligibility or

benefit determinations must be allowed to continue to do so under the Section 209(b) option.

ARGUMENT

THE SECRETARY'S REGULATIONS CONCERNING "DEEMING" IN SECTION 209(b) JURISDICTIONS ARE CONSISTENT WITH THE MEDICAID STATUTE AND ARE OTHERWISE REASONABLE

The regulations invalidated by the court of appeals in this case set maximum and minimum limits on the extent to which participating states that exercise the Section 209(b) option may "deem" income of an applicant's spouse to be "available" to the applicant for the purposes of determining eligibility and the amount of assistance under the Medicaid program. The regulations require 209(b) states to consider the income of the spouse of any aged, blind, or disabled Medicaid applicant as "available" to the applicant at least to the extent that the spouse's income would be considered in determining SSI eligibility. In addition, the regulations permit a 209(b) state to consider the income of an applicant's spouse as "available" to the applicant to the extent that such income would have been considered in determining eligibility and the amount of assistance under the state's 1972 Medicaid plan, even if such income would not be considered in determining SSI eligibility. 42 C.F.R. 435.734 (Pet. App. 36a).

Congress expressly delegated authority to the Secretary to prescribe controlling standards for calculating the income and resources of all Medicaid applicants and recipients. Under Section 1902(a)(17)(B) of the Act, all state Medicaid plans must include provisions for determining eligibility and the appropriate amount of assistance that take "into account only such income and resources as are, *as determined in*

accordance with standards prescribed by the Secretary, available to the applicant or recipient * * *" (42 U.S.C. 1396a(a)(17)(B); emphasis added). Moreover, if a state Medicaid plan contemplates extending assistance to any group of individuals who have income and resources that are greater than permissible under the relevant cash assistance program, the state must adopt a "medically needy" program. 42 U.S.C. 1396a(a)(10)(C).[9] See 42 U.S.C. 1396b(f)(1)(B)(i); H.R. Rep. No. 544, 90th Cong., 1st Sess. 183 (1967); see also S. Rep. No. 744, 90th Cong., 1st Sess. 294 (1967); H.R. Conf. Rep. No. 1030, 90th Cong., 1st Sess. 63 (1967). Here, too, Congress has authorized the Secretary to establish standards for calculating the income and resources of the "medically needy." 42 U.S.C. 1396a(a)(10)(C). Thus, unless the Secretary's regulations for determining "available" income are inconsistent with the Medicaid Act, or are arbitrary, capricious, or otherwise unlaw-

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[9] Under Section 1902(a)(10)(C) of the Act, if the state plan contemplates coverage of any group of individuals who have income and resources greater than permissible under the relevant cash assistance program, the plan must also provide:

> (i) for making medical assistance available to all individuals who would, except for income and resources, be eligible for aid or assistance under * * * [any cash assistance program] and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services, and
>
> (ii) that the medical assistance made available to all individuals not * * * [receiving cash assistance] shall be equal in amount, duration, and scope * * *.

42 U.S.C. 1396a(a)(10)(C). These requirements are subject to certain exceptions, some of which are discussed at pages 44-46, 39-40, *infra*.

ful, they are dispositive. *Batterton* v. *Francis*, 432 U.S. 416, 425-426 (1977). See also *INS* v. *Wang*, No. 80-485 (Mar. 2, 1981), slip op. 5. By authorizing the Secretary to prescribe standards for determining what income is "available,"

> Congress entrusts to the Secretary, rather than to the courts, the primary responsibility for interpreting the statutory term. In exercising that responsibility, the Secretary adopts regulations with legislative effect. A reviewing court is not free to set aside those regulations simply because it would have interpreted the statute in a different manner.

Batterton v. *Francis*, *supra*, 432 U.S. at 425.

As we demonstrate below, the regulations at issue in this case are fully consistent with the language and legislative history of the Medicaid Act. It was appropriate for the Secretary to allow "deeming" between spouses, even when one spouse is institutionalized, and it was well within the Secretary's discretion to draw the deeming lines as he did. The Secretary's regulations were adopted in light of Congress' manifest purpose in enacting the 209(b) option: to avoid the potential adverse consequences of imposing additional Medicaid obligations on participating states. See, *e.g.*, H.R. Rep. No. 92-231, 92d Cong., 1st Sess. 197 (1971); S. Rep. No. 92-1230, 92d Cong., 2d Sess. 47, 222, 394 (1972). In light of this purpose, the court of appeals should have been particularly reluctant to invalidate the regulations by substituting its judgment for that of the Secretary. *Batterton* v. *Francis*, *supra*, 432 U.S. at 431-432.

The goals of the Medicaid Act are ill-served if the states do not participate. If participating states respond to the court of appeals' interpretation of the

statute by shifting limited funds from other assistance programs to the Medicaid program or by simply reducing Medicaid benefits generally, the court will have advanced the interests of one group of public assistance beneficiaries at the expense of another equally deserving group. While the individual states must ultimately decide whether they will withdraw from the program, reduce Medicaid benefits, or shift money from other programs, the Secretary is better equipped to evaluate the likely consequences of particular regulations and the costs and benefits associated with such consequences than is the judiciary. Moreover, it is the Secretary to whom Congress has delegated responsibility for making such judgments.

A. The Secretary's Regulations Are Consistent With the Language, Legislative History, and Purpose of the Medicaid Statute

Under Section 1902(a)(17) of the Social Security Act, a state Medicaid Plan must include:

> reasonable standards (which shall be comparable for all groups * * *) for determining eligibility for and the extent of medical assistance under the plan which (A) are *consistent with the objectives of this subchapter*, (B) provide for taking into account only such income and resources *as are, as determined in accordance with standards prescribed by the Secretary*, available to the applicant or recipient * * *, (C) provide for reasonable evaluation of any such income or resources, and (D) *do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child* * * *.

42 U.S.C. 1396a(a)(17) (emphasis added). As noted at the outset, Congress specifically delegated authority to the Secretary to define the term "available" income as used in Subsection (B). Congress necessarily appreciated that the meaning of the term was not self-evident or susceptible of but a single interpretation; there would have been no need to authorize the Secretary to prescribe standards for determining the obvious. *Batterton* v. *Francis*, *supra*, 432 U.S. at 428. The Secretary's discretion to prescribe standards for determining what is "available" income for purposes of the Medicaid statute is necessarily broad, although not unlimited. *Ibid.*; see also *INS* v. *Wang*, *supra*, slip op. 5. The regulations at issue in this case are well within the broad authority granted in Section 1902(a)(17)(B) of the Act (42 U.S.C. 1396a(a)(17)(B)).

In authorizing the Secretary to define "available" income for Medicaid purposes, Congress did not leave the Secretary without guidance. Subsection (D) prohibits the consideration of the income of any of the applicant's relatives, *except his spouse* (or, under some circumstances, his parent). This provision obviously contemplates that the income of an applicant's spouse may be considered "available" in determining the applicant's eligibility for medical assistance and the amount of assistance to which the applicant is entitled[10] Congress plainly did not regard the consideration of the income of the applicant's spouse as inconsistent with the available income limitation of Subsection (B). To the contrary, as even

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[10] Indeed, Congress included Subsection (D) because it was aware of the state rules adopted under the predecessor Kerr-Mills medical assistance program that took into account the

the court of appeals acknowledged (Pet. App. 9a), the Act "establishes a broad principle, or expectation, that 'deeming' is appropriate between spouses * * *." Moreover, the statute draws no distinction between spouses separated by institutionalization and those who share a common household. The language of Subsection (D) is unequivocal and unqualified: the Secretary is empowered to limit the extent to which the states may consider income "available" to the applicant, but he may not permit the states to consider the financial responsibility of anyone other than the applicant or "such individual's spouse * * *."

The legislative history clearly reflects Congress' view, as expressed in Subsection (D), that it is appropriate to demand that an applicant's spouse make a reasonable contribution to the applicant's medical care before the state undertakes to pay the cost of that medical care from public funds. In summarizing the provisions of the Act, the House Committee Report explained:

> No income can be imputed to an individual unless actually available; and the financial responsibility of an individual for an applicant may be

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income of the applicant's relatives. See, *e.g.*, H.R. Rep. No. 213, *supra*, at 68; S. Rep. No. 404, *supra*, at 78; 111 Cong. Rec. 15804 (1965) (remarks of Sen. Ribicoff); *id.* at 15876 (remarks of Sen. McNamara); *id.* at 15813 (remarks of Sen. Hart); *id.* at 16149 (remarks of Sen. Saltonstall). See also 109 Cong. Rec. 2773 (1963) (remarks of Sen. Anderson) (concerning effectiveness of Kerr-Mills program and criticizing relative responsibility rules in effect in New York). If Congress had thought it appropriate to preclude consideration of the income of an applicant's spouse, it surely would have done so, as it did with respect to the income of all relatives except the applicant's spouse and (in some instances) his parents.

> taken into account only if the applicant is the individual's spouse or child who is under age 21 or blind or disabled.

H.R. Rep. No. 213, *supra*, at 10; see S. Rep. No. 404, *supra*, at 10. Use of the term "available" income in Section 1902(a)(17)(B) could not have been intended to exclude consideration of all income not in the applicant's hands. If so, there would be no "imput-[ation]" of income to the applicant. Congress obviously did not regard "actually available" income and "imputed" income as mutually exclusive. Furthermore, the relationship of the two independent clauses certainly suggests that the phrase "actually available" income was not understood to preclude consideration of the income of the Medicaid applicant's spouse. As the Committee later remarked:

> [I]t is proper to expect spouses to support each other and parents to be held accountable for the support of their minor children and their blind or * * * disabled children even though 21 years of age or older. Such requirements for support may reasonably include the payment by such relative, if able, for medical care.

H.R. Rep. No. 213, *supra*, at 68; see S. Rep. No. 404, *supra*, at 78.

Contrary to the court of appeals' assertion (Pet. App. 10a-11a), the propriety of demanding that an applicant's spouse contribute to the costs of the applicant's medical care to the extent possible is not based on any notion of economies achieved by sharing a common household. Rather, the "broad principle" (Pet. App. 9a) of interspousal responsibility is based on the relationship created by marriage. See *Califano* v. *Jobst*, 434 U.S 47, 52-53 n.8 (1977). For example, if any two people live together, there would

be savings, because they would "maintain a common household, 'shar[e]' income and expenses, * * * and constitut[e] a single economic unit" (Pet. App. 10a). Yet the statute clearly provides that the income of one household member may not be considered in determining the other household member's Medicaid eligibility, except if the two are married (or, in certain circumstances, if the person with whom the applicant shares a house is his parent). It is the marital relationship that is significant, and separation on account of institutionalization does not affect the propriety of asking that the applicant's spouse contribute to the extent that he can.[11]

By the same token, the Committee's reference to "absent fathers" and support orders (see Pet. App. 10a) in its more detailed explanation of the provisions of the Medicaid Act casts no doubt on the apparent relationship of Subsections (B) and (D). According to the Committee, Section 1902(a)(17) of the Act

> requires States to take into account only such income and resources as (determined in accordance with standards prescribed by the Secretary) are actually available * * *. Income and re-

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[11] The fact that an institutionalized applicant and his spouse no longer share a common household (see Pet. App. 10a-11a) may have implications concerning the amount that the spouse should be expected to contribute. But the institutionalization of an applicant has no bearing on the critical factor, namely, the marriage relationship. As described in some detail below (see pages 28-30, *infra;* see also note 5, *supra*), under the SSI statute the separation of spouses (by institutionalization or otherwise) is significant; because of the relationship between the SSI and Medicaid statutes, the Secretary has reasonably followed the distinctions drawn by the SSI statute in prescribing standards for determining "available" income under the Medicaid statute.

> sources taken into account, furthermore, must be reasonably evaluated by the States. These provisions are designed so that the States will not assume the availability of income which may not, in fact, be available or overevaluate income and resources which are available. Examples of income assumed include support orders from [*sic*] absent fathers, which have not been paid or contributions from relatives which are not in reality received by the needy individual.

H.R. Rep. No. 213, *supra*, at 67; see S. Rep. No. 404, *supra*, at 78. This passage confirms what is apparent from the language of the statute, namely, that Congress authorized the Secretary to prescribe standards limiting the extent to which participating states may consider income as "available" to the applicant and that the states must adopt reasonable standards for evaluating such income. Unless proscribed by the Secretary, however, the language of the statute and its legislative history make clear that a state may consider the income of a Medicaid applicant's spouse in determining eligibility or the amount of assistance. Consideration of income that is actually received by the applicant's spouse does not "assume" the availability of any income that is not, "in fact, * * * available." *Ibid.*

The reference to support orders directed to "absent fathers" provides no basis for the court of appeals' conclusion (Pet. App. 10a) that the consideration of the income of an institutionalized applicant's spouse is improper. Contrary to the court of appeals' apparent assumption, the "absent father" exception was the result of a particular social problem having no parallel in the case of assertedly "absent spouses" (see *ibid.*). Between 1961 and 1967, the percentage of families eligible for benefits under the AFDC

program (and therefore eligible for Medicaid) because the father was absent from the home increased from about 67% to 74%; the number of individuals receiving AFDC benefits because of an absent father who refused to contribute increased from about two million to almost four million during the same period. See S. Rep. No. 92-1230, 92d Cong., 2d Sess. 505 (1972).[12] The statement in the Committee Report concerning "absent fathers" and support orders referred to "absent fathers" in the AFDC context. One of the criteria for eligibility under the AFDC program is that the child have "been deprived of parental support or care" (see 42 U.S.C. 606(a), 603(a); see generally, *e.g.*, *King* v. *Smith*, 392 U.S. 309, 313 (1968). A support order directed to an "absent father," whose whereabouts or employment status may or may not be known, offers little basis for considering as "available" to the applicant the amount the absent father is directed to pay. See generally S. Rep. No. 92-1230, *supra*, at 506-519.

A totally different situation is presented when the applicant and his spouse are separated only because of the applicant's institutionalization. The spouse's location and income are generally ascertainable without difficulty. More important, the separation does not even suggest any break-down in the marital relationship. If, as the language of the statute and its legislative history make manifest, the states may (except to the extent proscribed by the Secretary)

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[12] Until the SSI program was enacted, disabled children under 18 were not even eligible for benefits under Title XIV of the Social Security Act (see 42 U.S.C. (1970 ed.) 1355) and the *total* number of recipients under Title X of the Act (Aid to the Blind) was only 98,313 as late as 1976 (United States Department of Health, Education, and Welfare, *Data on the Medicaid Program: Eligibility, Services, Expenditures* 75, Table 53 (rev. 1979 ed.)).

consider the income of an applicant's spouse in determining Medicaid eligibility, the applicant's institutionalization does not make that practice improper. Nowhere in the voluminous legislative hearings, reports or debates is there any suggestion of an "absent spouse" exception to the general "deeming" rule established in 42 U.S.C. 1396a(a)(17)(D).

The Secretary's decision to allow "deeming" between spouses is grounded in sound policy considerations as well. Requiring the states to ignore the income of an institutionalized Medicaid applicant's spouse would have a marked impact on the scope of the Medicaid program. The amount of money an institutionalized individual can earn is likely to be relatively small. Therefore, unless institutionalized Medicaid applicants have unearned income in excess of the applicable standard (see note 16, *infra*), they will all meet the income standards for Medicaid assistance. This result is required by the provisions of 42 U.S.C. 1396a(a)(10)(A) in SSI states. See pages 31-32, *infra*. There is no reason to impose that result upon 209(b) states, particularly in light of Congress' purpose for enacting the 209(b) option.

Unlike the Medicare program (adopted in 1965 as Title XVIII of the Social Security Act, 42 U.S.C. 1395 *et seq.*), Medicaid is not and was never intended to be a health insurance program. See *Fullington* v. *Shea*, 320 F. Supp. 500, 503 (D. Colo. 1970), aff'd, 404 U.S. 963 (1971). The more limited objective of the Medicaid Act is to enable "each State, as far as practicable under the conditions in such State" (42 U.S.C. 1396), to provide medical assistance to certain categories of the most needy individuals in our society. See generally H.R. Rep. No. 213, *supra*, at 66-67; S. Rep. No. 404, *supra*, at 77. The only individuals whom participating states were required to cover under the Medicaid Act, as passed in 1965, were the

recipients of cash assistance under the four categorical assistance programs. Pub. L. No. 89-97, 79 Stat. 345. Only if a state provided medical assistance to all cash assistance recipients could it then extend coverage to certain groups of the "less needy" who had income and resources greater than permissible under the cash assistance programs but who had incurred medical expenses that eliminated the excess income. See H.R. Rep. No. 213, *supra*, at 66-67; S. Rep. No. 404, *supra*, at 77; Pub. L. No. 89-97, 79 Stat. 345-346; see generally *Fullington* v. *Shea*, *supra*, 320 F. Supp. at 503-506. Congress did not intend, however, to allow the states to extend Medicaid coverage to individuals who were significantly less needy than the cash assistance recipients, however great their medical expenses. See H.R. Rep. No. 544, *supra*, at 117-119; S. Rep. No. 744, *supra*, at 176-177. Thus, the Medicaid Act is designed only to provide assistance to those least able to afford either the costs of medical care or private health insurance.[18]

In sum, the language, legislative history, and purpose of the Medicaid Act all support the conclusion that, in determining Medicaid eligibility and the amount of assistance, a state may (except to the extent proscribed by the Secretary) consider the income of an applicant's spouse as "available" to the

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[18] Even among the poor, however, the benefits of the Medicaid program are limited. With minor exceptions, only those persons who are over 65 years old, blind, disabled, or members of families with dependent children are eligible for medical assistance, whatever their income. For example, it has been estimated that only about 59% of those who had income in 1970 less than the national poverty standard were Medicaid recipients. See United States Department of Health, Education, and Welfare, *Data on the Medicaid Program: Eligibility, Services, Expenditures* 62-63 (rev. 1979 ed.).

applicant, whether or not the applicant and his spouse share a common household. See *Herweg* v. *Ray*, 619 F.2d 1265, 1272 (Ross, J.), 1280 (McMillian, J.) (8th Cir. 1980), petition for cert. pending, No. 79-1690 (filed Apr. 25, 1980); *Norman* v. *St. Clair*, 610 F.2d 1228, 1237 (5th Cir. 1980), petition for cert. pending, No. 80-498 (filed Sept. 27, 1980). "Available" income, as used in the Medicaid statute, includes all income received by the applicant or by those whom Congress has determined the state may reasonably expect to contribute to the costs of the applicant's medical care (*i.e.*, the applicant's spouse or, in some circumstances, his parent). The court of appeals therefore erred in concluding that Congress intended an exception to "the seemingly unequivocal expectation that spouses should support each other" (Pet. App. 10a) in cases where the spouses are not living together because of institutionalization. It was permissible for the Secretary, in prescribing regulations defining "available income" in 209(b) states, to permit "deeming" between spouses, including "deeming" between an institutionalized Medicaid applicant and his spouse.[14]

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[14] The Secretary has consistently interpreted the term "available" income, as used in 42 U.S.C. 1396a(a)(17)(B), to include the income of a Medicaid applicant's spouse. In 1966, Section D-4220(B)(4) of the United States Department of Health, Education, and Welfare, *Handbook of Public Assistance Administration* (Supplement D) required all states that participated in the Medicaid program but only covered recipients of cash assistance to include in their state plans provisions that:

> Provide that financial responsibility of any individual for any applicant or recipient of medical assistance will be limited to the responsibility of spouse for spouse and of parents for children under age 21, or blind, or permanently and totally disabled; and specify the extent to

As we now show, the "deeming" between spouses prescribed and permitted in the Secretary's regulations is not only consistent with the Medicaid Act but also reasonable. These regulations are derived from a careful analysis of the complex interlocking provisions of the Medicaid and SSI statutes.

B. The "Deeming" Regulations Applicable in Section 209(b) Jurisdictions Are Based on the Secretary's Reasonable Analysis of the Relationship Between the Medicaid and SSI Statutes

The regulations governing the extent to which participating states may consider the income of an applicant's spouse in determining Medicaid eligibility and the amount of assistance are based upon the Secretary's analysis of the interlocking statutory provisions of two complex social welfare programs, Medicaid and SSI. States that participate in the Medicaid program but fail to exercise the 209(b) option ("SSI states") are required by the regulations to consider the income of a Medicaid applicant's spouse only if that income would be considered in de-

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which the financial responsibility of any such relative is taken into account.

Identical requirements for states that covered the "medically needy" were imposed in Section D-4220(A)(5) of the *Handbook of Public Assistance* (Supplement D) (1966 ed.). At the same time, the regulations required the states to consider only such "income and resources as are *actually available*" (*id.* at Sections D-4220(B)(3) and D-4220(A)(4); emphasis added). See also 45 C.F.R. 248.21(a)(2) (rev. as of Jan. 1, 1972). Thus, like Congress, the Secretary found no inconsistency in requiring the states to consider only "actually available" income and yet permitting them to consider the income of the applicant's spouse without regard to whether the applicant and his spouse were separated by reason of institutionalization.

termining the applicant's eligibility for SSI benefits; if the income of the applicant's spouse would not be considered in determining the applicant's eligibiilty for SSI benefits, it may not be considered in determining the applicant's eligibility for Medicaid assistance in an SSI state. 42 C.F.R. 435.700, 435.723. The regulations invalidated by the court of appeals require 209(b) states (like SSI states) to consider the income of an applicant's spouse in determining Medicaid eligibility and the amount of assistance if the income would be considered in determining the applicant's eligibility for SSI benefits. But the regulations also permit 209(b) states to consider the income of a Medicaid applicant's spouse if that income would have been considered in determining the applicant's eligibility under his state's 1972 Medicaid plan. 42 C.F.R. 435.734. Careful examination of the Medicaid and SSI statutes shows that these distinctions are not arbitrary, capricious, or otherwise unlawful.

1. *Supplemental Security Income Eligibility*

The Secretary's Medicaid "deeming" regulations are based on his analysis of the relationship between the Medicaid and SSI statutes. Before examining the relationship between the two statutes, it is important to understand the method prescribed by Congress for determining eligibility for SSI benefits under Title XVI of the Social Security Act, 42 U.S.C. 1381 *et seq.*

Effective January 1, 1974, the federal government assumed responsibility for providing financial assistance to "needy" individuals who are aged, blind, or disabled. 42 U.S.C. 1381 *et seq.* In determining eligibility for benefits under the SSI statute, Congress has

mandated that the income of both the applicant and his spouse be considered for as long as they live together. Section 1611 of the Social Security Act defines an individual eligible for SSI benefits, in pertinent part, as follows:

> (2) Each aged, blind, or disabled individual who has an eligible spouse and—
>
> > (A) whose income (together with the income of such spouse) * * * is at a rate of not more than $2,628 [*i.e.*, $219 per month] * * * for the calendar year 1974, or any calendar year thereafter * * *.

42 U.S.C. 1382(a)(2)(A).[15] As used in this provision, the phrase "eligible spouse"

> means an aged, blind, or disabled individual who is the husband or wife of another aged, blind, or disabled individual and who has not been living apart from such other aged, blind, or disabled individual for more than six months.

42 U.S.C. 1382c(b). The SSI benefit amount payable to an eligible individual and his "eligible spouse" is determined by deducting the couple's monthly countable income (see 42 U.S.C. 1382a) from $219 (*i.e.*, the monthly income limitation prescribed in Section 1611 of the Act, 42 U.S.C. 1382(a)(2)(A)).[16] See 42 U.S.C. 1382(b)(2). Thus, under the SSI statute, an applicant who has an "eligible spouse" is ineligible for any benefit payment if he and his spouse have

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[15] In Section 1617 of the Social Security Act, Congress provided for cost-of-living increases in the benefit amounts payable under the SSI program. 42 U.S.C. 1382f.

[16] Institutionalized SSI applicants are subject to much lower income limitations. See 42 U.S.C. 1382(e)(1); see generally *Schweiker* v. *Wilson*, No. 79-1380 (Mar. 4, 1981).

combined countable income greater than $219 per month. By definition, an individual ceases to be an "eligible spouse" under the statute after he has lived apart from his spouse for six months.

If a married SSI applicant has lived apart from his spouse for six months, or if an SSI applicant lives with a spouse who is not aged, blind, or disabled, the applicant is eligible for SSI benefits only if he is aged, blind, or disabled and his countable income (see 42 U.S.C. 1382a) is not at a rate of more than "$1752 * * * for the calendar year 1974 or any calendar year thereafter [*i.e.*, $146 per month]." 42 U.S.C. 1382(a)(1)(A). The SSI benefit amount is determined by deducting the individual's monthly countable income from $146. But under Section 1614(f)(1) of the Act,

> [f]or purposes of determining eligibility for and the amount of benefits for any individual who is married and whose spouse is living with him in the same household but is not an eligible spouse, such individual's income and resources shall be deemed to include any income and resources of such spouse, whether or not available to such individual, except to the extent determined by the Secretary to be inequitable under the circumstances.

42 U.S.C. 1382c(f)(1). A married SSI applicant who lives with his spouse who is not aged, blind, or disabled is, therefore, entitled to SSI benefit payments only if their *combined* countable income does not exceed $146 per month.[17] Thus, "deeming" between spouses is generally mandated by statute in determining SSI eligibility.

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[17] An unmarried SSI applicant is, of course, subject to the same income limitations. 42 U.S.C. 1382(a)(1)(A), (b)(1).

2. *Medicaid Eligibility in SSI States*

The Secretary's regulations prohibit SSI states—that is, states that participate in the Medicaid program but fail to exercise the 209(b) option (42 U.S.C. 1396a(f))—from considering the income of a Medicaid applicant's spouse as "available" to the applicant if that income would not be considered in determining SSI eligibility. The regulations also require SSI states to consider the income of a Medicaid applicant's spouse whenever that income would be considered in determining SSI eligibility. As we now demonstrate, this congruence is dictated by the interlocking provisions of the Medicaid and SSI statutes.

a. *Eligibility for Medical Assistance under 42 U.S.C. 1396a(a)(10)(A).* All SSI states must provide medical assistance to all SSI benefit recipients. 42 U.S.C. 1396a(a)(10)(A). With carefully limited exceptions, individuals who are ineligible for benefits under the SSI program are also ineligible for medical assistance under the Medicaid program.[18] If SSI states were to consider the income of a Medicaid applicant's spouse as "available" to the applicant for purposes of determining Medicaid eligibility even though that income is not considered in determining

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[18] The major exception, of course, is established in the "medically needy" provision (see 42 U.S.C. 1396a(a)(10)(C)). There are, however, several others, some of which are listed in 42 U.S.C. 1396a note. See, *e.g.*, Pub. L. No. 94-566, Section 503, 90 Stat. 2685; Pub. L. No. 93-233, Section 13(c), 87 Stat. 965; Pub. L. No. 93-66, Section 230, 87 Stat. 159; Pub. L. No. 93-66, Section 231, 87 Stat. 159, as amended by Pub. L. No. 93-233, Section 13(b)(1), 87 Stat. 964; Pub. L. No. 92-603, Section 249E, 86 Stat. 1429, as amended by Pub. L. No. 93-66, Section 233, 87 Stat. 160. This case does not involve individuals who qualify for Medicaid benefits as members of families with dependent children receiving benefits under the AFDC program (42 U.S.C. 601 *et seq.*).

SSI eligibility, some SSI benefit recipients would be denied Medicaid assistance, contrary to the express command of Section 1902(a)(10)(A) of the Act, 42 U.S.C. 1396a(a)(10)(A). It follows, therefore, that although Section 1902(a)(17)(B) of the Act, 42 U.S.C. 1396a(a)(17)(B), would allow a state to consider the income of the applicant's spouse as "available" to the applicant for purposes of determining Medicaid eligibility, SSI states cannot be permitted to consider such income as "available" to the applicant if it would not be considered in determining SSI eligibility.[19]

Moreover, subject to the other exceptions previously mentioned (see note 18, *supra*), no participating state may provide Medicaid benefits to any individual who is ineligible for SSI benefits, unless the state adopts a "medically needy" program under Section 1902(a)(10)(C) of the Act, 42 U.S.C. 1396a(a)(10)(C). Unless the state considers all of the income of a Medicaid applicant that would be considered in determining the applicant's eligibility for SSI benefits, it is impossible to distinguish the "medically needy"

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[19] For example, but for the Secretary's regulations, if an applicant became eligible for and received SSI benefits because his noneligible spouse no longer lived in his home and therefore her income was not attributed to him, he would be eligible for Medicaid benefits in an SSI state. But if the same individual were unwilling to accept SSI benefits and applied directly to the state Medicaid agency for benefits under a program for the "medically needy" with higher income standards, he might nevertheless be denied medical assistance if the state Medicaid rules continued to take into account the income of his spouse. This discrimination between needy individuals and equally needy individuals who, for their own reasons, are unwilling to accept SSI benefits clearly was not intended by Congress. See 40 Fed. Reg. 60074 (1975).

from those individuals who are not receiving SSI benefits but are nevertheless eligible for SSI benefits. The distinction is significant. No state is entitled to federal financial assistance for providing Medicaid benefits to any member of a family that has countable income, "determined, in accordance with standards prescribed by the Secretary, to be equivalent to 133⅓ percent of the highest amount which would ordinarily be paid to a family of the same size without any income * * *" (42 U.S.C. 1396b(f)(1)(B)(i)) under the state AFDC program. But this limitation is inapplicable with respect to state medical assistance provided to individuals who are eligible to receive SSI benefits, even if they do not actually receive SSI benefit payments. See 42 U.S.C. 1396b(f)(4)(A), (B). The distinction is also important for the purpose of determining the scope of the services a participating state is obliged to furnish under its Medicaid plan (see 42 U.S.C. 1396a(a)(10)(B)(i), (C)(III)) and the kinds of charges that may be imposed on Medicaid beneficiaries (see 42 U.S.C. 1396a(a)(14)).

More significant, a participating state's *option* to adopt a "medically needy" program becomes an *obligation* to adopt a "medically needy" program covering the aged, blind, and disabled if the state provides medical assistance to

> any group of individuals who are not * * * [SSI recipients] and who do not meet the income and resources requirements of the * * * [SSI statute] as determined in accordance with standards prescribed by the Secretary * * *.

42 U.S.C. 1396a(a)(10)(C). The Secretary's responsibility for assuring that the requirements of this provision are satisfied cannot be carried out

unless, in making Medicaid determinations, participating states include at least the income that would be considered in determining the applicant's eligibility for SSI benefits. For example, if a state were to ignore the income of a Medicaid applicant's spouse under circumstances in which that income would be considered for the purpose of determining SSI eligibility, the applicant might be found eligible for medical assistance even though he would be ineligible for SSI benefits. By the terms of the Medicaid statute, however, such an individual is eligible for medical assistance only if the state adopts a "medically needy" program.

Because of the relationship between the Medicaid and SSI statutes, then, (1) all SSI states must ignore the income of a Medicaid applicant's spouse if that income would not be considered in determining SSI eligibility, and (2) all participating states, whether SSI states or 209(b) states, must consider the income of the applicant's spouse as "available" to the applicant to the extent that such income would be considered in determining SSI eligibility. The Secretary's regulations incorporate those requirements. 42 C.F.R. 435.700, 435.723, 435.734.[20] It is important to note that the Secretary's regulations are not based on

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[20] The court of appeals recognized that the relationship of the Medicaid and SSI statutes required SSI states to consider the income of a Medicaid applicant's spouse as "available" to the applicant to the same extent that the income would be considered in determining SSI eligibility (Pet. App. 3a, 5a, 7a). The court failed to appreciate the limited operation and effect of the 209(b) option, however, and consequently failed to understand that the reasons for requiring SSI states to consider the income of the applicant's spouse to the extent that such income would be considered in determining SSI eligibility are equally applicable in 209(b) states. See pages 36-49, *infra*.

the notion that the SSI statute changed or amended the meaning of the term "available" income, as used in the Medicaid statute. Rather, as discussed in Part A of this brief, the term "available" income as used in the Medicaid statute includes the income of the applicant's spouse, whether or not they live together; the interlocking provisions of the two statutes, however, provide the basis for the precise requirements of the regulations.

b. *Eligibility for Medical Assistance under 42 U.S.C. 1396a(a)(10)(C).* Under Section 1902(a)(10)(C)(i) of the Act, 42 U.S.C. 1396a(a)(10)(C)(i), a state may provide medical assistance to individuals "who would, except for income and resources" be eligible for SSI benefits, subject to the limitations imposed by 42 U.S.C. 1396b(f). Standards for determining eligibility and the amount of assistance, however, must be "comparable" for all groups that are covered under the state Medicaid plan. 42 U.S.C. 1396a(a)(17). The Secretary has concluded that "comparable" standards in this context requires that the states use the same method for calculating the income of the "medically needy" as is used in calculating the income of the "categorically needy." See 40 Fed. Reg. 60074 (1975).

The basis for this conclusion is relatively straightforward. The primary purpose of the "medically needy" provision is to permit participating states to provide medical assistance to individuals whose income is slightly in excess of the standards established under the categorical assistance plans but who incur medical expenses that substantially eliminate their "excess income."[21] As noted above (see note 19,

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[21] See, *e.g.*, H.R. Rep. No. 544, *supra*, at 117-119; S. Rep. No. 744, *supra*, at 176; see generally H.R. Rep. No. 213, *supra*, at 66-67, 168; S. Rep. No. 404, *supra*, at 77-78, 79.

supra), if, in determining Medicaid eligibility, states take into account income that would be ignored in determining eligibility for SSI benefits, even those who are eligible for SSI benefits may be found ineligible for medical assistance. Also, for reasons already mentioned, it is essential that the Secretary be able to distinguish between those who meet the income and resources limitations of the SSI statute and all other non-SSI recipients covered under state Medicaid plans. See 42 U.S.C. 1396b(f), 1396a(a)(10)(C)(III), 1396a(a)(14). Finally, a state plan that includes only one method for calculating an applicant's income is "consistent with simplicity of administration" and for that reason is in "the best interests of the recipients" (see 42 U.S.C. 1396a(a)(19)).

Thus, as the court of appeals seemed to recognize (Pet. App. 3a, 5a, 7a), the regulations requiring SSI states to consider the income of a Medicaid applicant's spouse as "available" to the applicant in the same manner as the income would be considered in determining SSI eligibility are virtually compelled by the statutory scheme Congress has established and are not arbitrary, capricious, or otherwise unlawful. See *Herweg* v. *Ray*, *supra*, 619 F.2d at 1281-1289 (McMillian, J.); *Norman* v. *St. Clair*, *supra*, 610 F.2d at 1238. For the reasons that follow, the regulations governing the extent to which 209(b) states may consider the income of an applicant's spouse in determining Medicaid eligibility also are consistent with the statute and are reasonable.

3. *Medicaid Eligibility in 209(b) States*

a. *Purpose and Effect of the 209(b) Option.* Adoption of the SSI program was expected to result in a tremendous increase in the number of aged, blind, and disabled individuals who would be eligible for cash assistance and, consequently, eligible for Medi-

caid benefits under Section 1902(a)(10)(A) of the Social Security Act, 42 U.S.C. 1396a(a)(10)(A). See H.R. Rep. No. 92-231, *supra*, at 227-228.[22] Congress sought to alleviate the burden that would be imposed on participating states because of this requirement by enacting Section 209(b) of the Social Security Amendments of 1972 (Pub. L. No. 92-603, 86 Stat. 1381), which added Section 1902(f) to the Act:

> Notwithstanding any other provision of this title, except as provided in subsection (e) [added by Pub. L. No. 92-603, Section 209(a), 86 Stat. 1381], no State shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of title XVI [of the Social Security Act]) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this title and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1903(f) [42 U.S.C. 1396b] (after deducting such individual's payment under title XVI, and incurred expenses for medical care as defined in section 213 of the Internal Revenue Code of 1954) is not in excess of the standard

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[22] The House Committee estimated that in the first year of operation the number of aged, blind, and disabled individuals who would be eligible under the new SSI program would be almost twice the number of individuals eligible under the old adult categorical assistance plans. See H.R. Rep. No. 92-231, *supra*, at 227-228, Table 12.

> for medical assistance established under the State plan as in effect on January 1, 1972.

42 U.S.C. 1396a(f).

In 1972, participating states were only required to provide medical assistance to those aged, blind, or disabled individuals who were recipients of cash assistance under one of the categorical assistance programs (42 U.S.C. (1970 ed.) 1396a(a)(10)(A)). Effective January 1, 1974, the old categorical assistance programs were to be repealed (and replaced) by the SSI program. It is plain, therefore, that the intended operation and effect of the 209(b) option was only to limit the obligations of participating states under 42 U.S.C. 1396a(a)(10)(A). A state that exercised the option could only be required to provide medical assistance to those aged, blind, or disabled individuals who were eligible for SSI benefits *and* who would have been eligible for medical assistance under the state's January 1972 Medicaid plan. But, for the purpose of determining who would have satisfied the income limitations of the state's 1972 plan, SSI benefit payments and incurred medical expenses were to be excluded.[23]

States that exercise the 209(b) option are not exempt from any of the other requirements of the Medicaid Act. If, in addition to the coverage required by the terms of 42 U.S.C. 1396a(f), 209(b) states choose to cover optional groups, they are subject to the same restrictions as other participating states. See, *e.g.*, 42 U.S.C. 1396b(f), 1396a(a)(10)(B)(i), (C). Consequently, 209(b) states, in making Medicaid deter-

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[23] In Section 13(a)(10) of Pub. L. No. 93-233, 87 Stat. 962, the provision was modified to require the exclusion of state supplementary payments as well as SSI benefit payments and medical expenses.

minations, must consider the income of an applicant's spouse as "available" to the applicant if that income would be considered in making SSI eligibility determinations, for essentially the same reasons that SSI states must do so.

Immediately before the Social Security Amendments of 1972 became effective, Congress added the following provisions to 42 U.S.C. 1396a(f):

> In [209(b)] States which provide medical assistance to individuals pursuant to * * * [42 U.S.C. 1396a(a)(10)(C)], an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under * * * [42 U.S.C. 1396a(a)(10)(A)] if that individual is, or is eligible to be (1) an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under * * * [42 U.S.C. 1396a(a)(10)(A)], or (2) an eligible individual or eligible spouse, as defined in title XVI [of the Social Security Act], with respect to whom supplemental security income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under * * * [42 U.S.C. 1396a(a)(10(C)]. In States which do not provide medical assistance to individuals pursuant to * * * [42 U.S.C. 1396a(a)(10)(C)], an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for med-

> ical assistance under * * * [42 U.S.C. 1396a(a)(10)(A)].

Pub. L. No. 93-233, Section 13(a)(10)(D), 87 Stat. 962-963. Thus, in a 209(b) state that has a "medically needy" program, an individual who is eligible for medical assistance under the state's 1972 plan because of the 209(b) spend-down provision is classified with SSI recipients only if (1) he is eligible for a state supplementary payment *and* the state provides medical assistance to other state supplementary payment recipients equal to that provided to SSI recipients (see 42 U.S.C. 1396a(a)(10)(C)(III) and 1396b(f)(4)(C)) or (2) he is eligible for SSI benefits. If the individual is not eligible for SSI benefits or a state supplementary payment (see 42 U.S.C. 1396d(j), 1382e), he is classified with the other "medically needy," and the state is entitled to federal financial assistance under the Medicaid program only if his countable income is not greater than 133⅓% of the applicable AFDC payment amount (42 U.S.C. 1396b(f)). In a 209(b) state that does not have a "medically needy" program, an individual who meets the requirements of the state's 1972 plan because of the 209(b) spend-down provision is classified with SSI recipients, and therefore the state does not become obligated to adopt a "medically needy" program (42 U.S.C. 1396a(a)(10)(C)) by providing medical assistance to him, even if he is ineligible for SSI benefits. Also, by virtue of this provision, the income limitations of 42 U.S.C. 1396b(f) are inapplicable to these individuals.

Adoption of these exceptions to the general requirements of the Medicaid Act for 209(b) jurisdictions confirms the previous observation based on the lan-

guage of the provision as originally enacted. Except to the extent specifically provided for in 42 U.S.C. 1396a(f), 209(b) jurisdictions that choose to offer Medicaid coverage to non-SSI recipients (*i.e.*, optional groups) are subject to all of the general requirements of the Medicaid statute. If the intended or anticipated effect of the 209(b) option had been to relieve states that exercised the option of all the limitations of the Medicaid statute, there would have been no reason to adopt these very specific and narrow exceptions to the otherwise applicable requirements of the statute.

The legislative history of the 1972 amendments provides further support for the conclusions that are virtually compelled by the language of the 209(b) option (42 U.S.C. 1396a(f)). According to the Senate Committee Report, the 209(b) option

> gives States the option of covering under medicaid aged, blind and disabled persons made *newly eligible for cash assistance* as a result of the increases in payment levels to these persons provided under * * * [the] bill.
>
> No State would be required to furnish medical assistance *to any individual receiving aid as a needy aged, blind or disabled adult unless the state would be (or would have been) required to furnish such assistance to such individual under its medicaid plan that was in effect on January 1, 1972.* However, if a state should elect to provide medicaid benefits on the basis of its January 1, 1972 medical assistance standard it would be required to incorporate a spend-down provision comparable to that contained in section 1903(f) [see 42 U.S.C. 1396b(f)(2)] * * *.

S. Rep. No. 92-1230, *supra*, at 222 (emphasis added); see also *id.* at 47, 394; H.R. Rep. No. 92-231, *supra*,

at 197;[24] H.R. Conf. Rep. No. 92-1605, 92d Cong., 2d Sess. 46-47 (1972). The 209(b) option was intended to allow the states to avoid *expanded* Medicaid obligations resulting from the anticipated increase in the number of individuals who would be eligible for cash assistance under the SSI program. States that exercise the option are not required to provide Medicaid assistance to

> persons who are eligible for Supplemental Security Income but would not have been eligible for assistance under the State welfare programs for the aged, blind, and disabled as they were in effect prior to the initiation of this new program.

S. Rep. No. 92-1230, *supra*, at 394; see also S. Rep. No. 93-553, 93d Cong., 1st Sess. 7-8, 56-57 (1973);

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[24] Under present law, States are required to cover under medicaid all people eligible for cash assistance payments. If this provision were carried over into the new assistance programs, many thousands of additional people, the great majority of whom would be people made *newly eligible for assistance to the aged, blind, and disabled*, would be required to be covered under medicaid. In view of the serious financial and other problems of many State medicaid programs, your committee decided not to require the States to cover the newly eligible but rather leave the decision up to each individual State. Your committee's bill would, therefore, provide that despite any other requirements of Title XIX [of the Social Security Act], no State shall be required to provide medicaid coverage to any individual or family member in any month where such person would not have been eligible for such assistance under the State plan in effect on January 1, 1971.

H.R. Rep. No. 92-231, *supra*, at 197 (emphasis added); see *id.* at 301. In conference, the January 1, 1972 date found in the Senate version was adopted.

Staffs of Senate Comm. on Finance and House Comm. on Ways and Means, 92d Cong., 2d Sess., *Summary of Social Security Amendments of 1972: Public Law No. 92-603 (H.R. 1)* 27 (Comm. Print 1972); H.R. 3153, 93d Cong., 1st Sess., *Social Security Amendments of 1973, Brief Description of Senate Amendments* 25, 26 (Conf. Comm. Print 1973).

Because the only individuals the states were required to cover under their Medicaid plans in 1972 were recipients of cash assistance under one of the categorical assistance programs, the only purpose the 209(b) option could have had was to excuse the states from providing medical assistance to the additional group of individuals who became eligible for benefits under the new SSI program.[25] Thus, the purpose and effect of the 209(b) option is solely to provide a partial exemption from the requirements of 42 U.S.C. 1396a(a)(10)(A). A state that exercises the option cannot be required to cover SSI benefit recipients, unless those individuals would have been eligible for Medicaid benefits under the state's 1972 Medicaid plan. All of the other requirements of the Medicaid statute are fully operative.

If a Medicaid applicant in a 209(b) state is an SSI recipient and he would also have been eligible under the state's 1972 Medicaid plan, the state must provide medical assistance, as required in Section 1902(a)(10)(A). And in a 209(b) state, as in an SSI state, a Medicaid applicant who is not an SSI benefit recipient is eligible for medical assistance only

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[25] The legislative history is silent as to the purpose of the 209(b) spend-down provision. However, the provision undoubtedly was included because Congress assumed that the states most likely to exercise the 209(b) option were those with relatively low 1972 income limitations.

if (1) he meets the requirements of one of the optional categories (see, *e.g.*, 42 U.S.C. 1396a(a)(10)(C)) and the state has chosen to provide medical assistance to that category of potential Medicaid beneficiaries or (2) he is within one of the other exceptions to the general rule that non-SSI recipients are ineligible for Medicaid benefits (see, *e.g.*, Pub. L. No. 93-233, Section 13(c), 87 Stat. 965). Hence, Section 1902(f) of the Act, 42 U.S.C. 1396a(f), provides no basis for ignoring the interrelationship of the Medicaid and SSI statutes. On the contrary, the interlocking provisions of the two statutes are as important in 209(b) states as they are in SSI states, and for precisely the same reasons.

b. *Eligibility for Medical Assistance under 42 U.S.C. 1396a(a)(10)(A) and 1396a(a)(10)(C).* As stated above, with carefully limited exceptions, an individual who is ineligible for SSI benefits is also ineligible for Medicaid in SSI states as well as in 209(b) states. For example, the basic benefit amount initially payable under the SSI statute for an aged, blind, or disabled individual (*i.e.*, $130 per month, Pub. L. No. 92-603, Section 301, 86 Stat. 1466) was higher than that paid by most states in July 1972. See S. Rep. No. 92-1230, *supra*, at 78-81, Tables 3 & 4; see also *id.* at 75; H.R. Rep. No. 92-231, *supra*, at 199. In those states with benefit levels for the aged, blind, and disabled that were higher than the SSI standards, adoption of the SSI program would have resulted in a reduction of benefits for some individuals and a complete loss of benefits for others, with the consequence for the latter of the loss of Medicaid benefits in states that did not have "medically needy" programs. To avoid causing a reduction in benefit payments to any aged, blind, or disabled individual who was receiving cash assistance in De-

cember 1973, Congress required participating states to make supplementary payments to those individuals. Pub. L. No. 93-66, Section 212, 87 Stat. 155-158, as amended by Pub. L. No. 93-233, Section 10, 87 Stat. 957-958; see 119 Cong. Rec. 22606 (1973) (remarks of Sen. Long); *id.* at 22645 (remarks of Rep. Mills); S. Rep. No. 93-249, 93d Cong., 1st Sess. 24-25 (1973). The amount of the required state supplementary payment is equal to the difference between the individual's "December 1973 income" and the individual's income in any subsequent month. Pub. L. No. 93-66, Section 212(a)(3), 87 Stat. 155-156. The state is only required to make supplementary payments to individuals who were *receiving* benefits in December 1973 and only for so long as the individual's "December 1973 income" is greater than the individual's SSI benefit payment, if any, and any other income the individual might have. Continuous Medicaid coverage for mandatory state supplementary payment recipients was assured in Pub. L. No. 93-233, Section 13(c), 87 Stat. 965; see S. Rep. No. 93-553, *supra*, at 8, 56.

Mortality and the cost of living increase provision in the SSI statute (42 U.S.C. 1382f) make the mandatory state supplementary payment provision self-terminating. In light of the limited nature of this provision and the other "grandfather" clauses included in the legislation effecting the transfer of responsibility to the federal government for providing financial assistance to the aged, blind, and disabled (see, *e.g.*, 42 U.S.C. 1382(g), (h); Pub. L. No. 93-66, Section 211, 87 Stat. 154-155), and in light of the purpose of the 209(b) option, it is inconceivable that Congress intended to require states exercising that option to provide Medicaid coverage to any individual who is ineligible for SSI benefits, except as may

result from the operation of the 209(b) spend-down clause.

Similarly, it is most unlikely that Congress intended to allow 209(b) jurisdictions to circumvent the carefully drawn limitations on the state's option to provide federally-supported medical assistance to certain individuals who are ineligible for SSI benefits. For example, under Section 1616 of the Social Security Act, states may voluntarily make supplementary payments to an individual who is aged, blind, or disabled but ineligible for SSI benefits because of his income. 42 U.S.C. 1382e. If a state establishes a voluntary supplementary payment program, it may also provide medical assistance "of the same amount, duration, and scope" as that provided to SSI recipients to those who receive or are eligible to receive state supplementary payments, without adopting a "medically needy" program. See 42 U.S.C. 1396a(a)(10)(C)(III). But the state is entitled to receive federal financial assistance for providing medical assistance to an individual who is eligible for an optional state supplementary payment (but ineligible for SSI benefits) only if the individual's gross income is not in excess of 300% of the SSI benefit rate. 42 U.S.C. 1396b(f)(4)(C).

Unless a Medicaid applicant is eligible for SSI benefits or qualifies under one of the limited exceptions to the general rule, he is ineligible for Medicaid benefits under 42 U.S.C. 1396a(a)(10)(A) in either an SSI state or a 209(b) state. As discussed in some detail above (see pages 32-34, *supra*), if the Secretary is to carry out his responsibility under the Medicaid program, it is essential that he be able to determine whether the non-SSI benefit recipients covered under state Medicaid plans are eligible for SSI benefits. Without redetermining the Medicaid eligibility of

every non-SSI recipient covered under every state plan, it is impossible to make that determination unless the states consider the income of an applicants' spouse to the extent that it would be considered in determining SSI eligibility. Thus, in making Medicaid determinations, 209(b) states (like SSI states) must consider the income of an applicant's spouse at least to the extent that it would be considered in determining SSI eligibility.

In addition to *requiring* 209(b) states to consider the income of a Medicaid applicant's spouse as "available" to the applicant whenever that income would be considered in determining SSI eligibility, the Secretary's regulations *permit* 209(b) states to consider the income of a Medicaid applicant's spouse as "available" to the applicant if such income would have been considered under the states' 1972 Medicaid plan. By its terms, Section 1902(f) of the Act, 42 U.S.C. 1396a(f), requires the Secretary to allow 209(b) states to consider the income of a Medicaid applicant's spouse to the extent that they would have lawfully done so in 1972. As demonstrated in Part A of this brief, under Section 1902(a)(17) of the Act, 42 U.S.C. 1396a(a)(17), participating states may consider the income of a Medicaid applicant's spouse whether the applicant and his spouse live together or not. For reasons already mentioned (see pages 35-36, *supra*), the Secretary's judgment that 209(b) states should use the same method of calculating income for the optional coverage groups as is used in determining the eligibility of the categorically needy is sound.

The court of appeals' interpretation of the statutes effectively turns the statutory scheme envisioned by Congress on its head. As the court of appeals seems to have recognized (Pet. App. 3a, 5a, 7a), SSI states must consider the income of a Medi-

caid applicant's spouse as "available" to the applicant if that income would be considered in determining the applicant's eligibility for SSI benefits. The legislative history of the 209(b) option is clear: its only purpose was to permit participating states to avoid the tremendous increase in their Medicaid obligations that would result from requiring them to cover all SSI recipients. Yet, if 209(b) states are prohibited from considering the income of a Medicaid applicant's spouse even though such income is considered in determining eligibility in SSI states and would have been considered under the 209(b) states' 1972 plans, Congress' purpose in enacting the provision will have been completely frustrated. Ignoring the income of a Medicaid applicant's spouse necessarily results in an increase in the scope of Medicaid coverage; individuals who would not have been eligible under the 209(b) states' 1972 Medicaid plans, and who would not be eligible in SSI states today, will become eligible in 209(b) states. Similarly, allowing 209(b) states to ignore the income of a Medicaid applicant's spouse even though such income would be considered in determining SSI eligibility would give the 209(b) option a wholly unintended effect. Subject to the exceptions (and concomitant limitations) noted above, individuals who are ineligible for SSI benefits are also ineligible for Medicaid benefits.[26]

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[26] Even if the court of appeals were correct in noting that "there is no required federal statutory 'deeming' in the 209 (b) jurisdictions" (Pet. App. 8a), the Secretary's decision to require all participating states to consider the income of the Medicaid applicant's spouse to the extent that it is considered in determining SSI eligibility is not inconsistent with the Medicaid Act, arbitrary, capricious, or otherwise unlawful. As used in the Medicaid Act, the term "available" income includes the income of an applicant's spouse, whether they live together or not. See Part A, *supra*. For reasons already

In sum, the Secretary's regulations requiring 209 (b) states to consider the income of an applicant's spouse as "available" to the applicant if it would be considered in determining SSI eligibility, and allowing 209(b) states to consider the income of an applicant's spouse to the extent that they would have done so in 1972, are consistent with the Medicaid statute and reasonable. The regulations, therefore, are entitled to legislative effect.

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stated, the Secretary must be able to determine whether the individuals for whom the state proposes to provide medical assistance are eligible for SSI benefits or qualify under one of the optional categories. The Secretary's responsibility for assuring that the coverage provided under each state plan is consistent with the requirements of the Medicaid Act, in theory as well as in practice, thus provides ample justification for requiring all Medicaid states to consider the income of an applicant's spouse at least to the extent that the income would be considered in determining SSI eligibility. Furthermore, because of the close relationship that has always existed between the categorical assistance programs and the Medicaid program, the SSI statute provides a particularly appropriate model for rules concerning income evaluation.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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MARCH 1981

★ U. S. GOVERNMENT PRINTING OFFICE: 1981 342606 293

FILED
APR 17 1981
ALEXANDER L. STEVAS, CLERK

No. 80-756
IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1980

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, AND ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION,

Petitioners,

vs.

GRAY PANTHERS,

Respondent.

BRIEF FOR THE RESPONDENT

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QUESTION PRESENTED

Whether Medicaid regulations promulgated by the Department of Health and Human Services, which permit certain states to assume that a portion of an individual's income is available to the spouse in a nursing home, without regard to whether in fact that income is available, are inconsistent with the Medicaid statute, as the court of appeals so determined.

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IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1980

No. 80-756

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, AND ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION,

PETITIONERS,

v.

GRAY PANTHERS,

RESPONDENT.

On Writ Of Certiorari To The United States Court Of Appeals For The District of Columbia Circuit

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BRIEF FOR THE RESPONDENT

STATEMENT OF THE CASE

1. Since its inception in 1965, the Medicaid statute, Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq., has required states to use "reasonable standards ... for determining eligibility for and the amount of assistance", to take

"into account only such income and resources as are ... available to the applicant or recipient," and to "provide for reasonable evaluation of any such income and resources ...." 42 U.S.C. §1396a(a)(17)(B), (C). It also forbids states from "tak[ing] into account the financial responsibility of any individual for any applicant or recipient of assistance ... unless such applicant or recipient is such individual's spouse or such individual's child ...." 42 U.S.C. §1396a(a)(17)(D).

Pursuant to these directives, the Department of Health, Education and Welfare ("HEW") and its successor, the Department of Health and Human Services ("HHS"),[1/] have required from the outset that states only consider income and resources which are "actually available" or "in hand" or "under the control of" the applicant. Despite this requirement, however, the

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1/ Future references in this brief will generally be to "HHS". It should be assumed that that expression necessarily refers to "HEW" where chronologically applicable. See 20 U.S.C. §3508.

agency never undertook to enforce its apparent meaning, thus permitting states to deem, or assume, that income was available to an applicant spouse without regard to whether it was in fact available. This presumption of availability, or "deeming", was accepted without question, regardless of individual circumstances, including whether the applicant spouse was living in a nursing home and thereby involuntarily separated from the other spouse.

In 1972, Congress replaced the three federal-state cash assistance programs for the aged, blind and disabled with one federally administered and financed program, Supplemental Security Income ("SSI"). Title XVI of the Social Security Act, 42 U.S.C. §1381 et seq., as added by Pub.L. 92-603, §301, 86 Stat. 1465. At the same time, Congress altered the methodology for determining Medicaid eligibility for the so-called "categorically needy". See 42 C.F.R. §435.4 (1979). It provided an alternative method to determine the eligibility as categorically needy of the aged, blind and disabled.

This was the "209(b)" option, which permitted states to base eligibility for the aged, blind and disabled on the eligibility rules validly in effect on January 1, 1972. 42 U.S.C. §1396a(f), as added by Pub.L. 92-603, §209(b), 86 Stat. 1381 (1972). Thus, while most states became locked into the SSI rules for purposes of determining Medicaid eligibility for the aged, blind and disabled, the rest remained subject to the rules and regulations in place in 1972.

A significant aspect of the 209(b) option was its requirement that states employ a "spenddown" in determining eligibility. Applicants were permitted to establish eligibility by reducing gross income by the amount of incurred medical expenses. Prior to the passage of the 209(b) option, only those states which had elected to provide coverage to the "medically needy", see 42 U.S.C. §1396a (a)(10)(C); 42 C.F.R. §435.4 (1979), utilized a spenddown -- and then only for the medically needy. In short, while selection of the 209(b) option permitted a state to use lower eligibility levels

than were employed in the SSI program, it also mandated use of the liberal spend-down mechanism for determining categorically needy eligibility.

Despite passage of the SSI program and the 209(b) option in 1972, and implementation on January 1, 1974, HHS did not alter the regulations applicable to the determination of "available" income and resources until April 13, 1977. See 42 Fed.Reg. 2684 (Jan. 13, 1977). Until that date, all states were presumptively subject to the regulations which had been in effect, in generally the same form, since 1966. As previously noted, those regulations required states only to consider "actually available" income, and did not distinguish between states based on their 209(b) or "SSI" status. When the change was finally made, however, HEW devoted its explanation entirely to the new requirement that the SSI states utilize the SSI rules. The "new" regulations for the 209(b) states simply restated the message of the option, 42 U.S.C. §1396a(f), by declaring that "consideration of income and resources may not be more restrictive

than that included in the State's January 1972 title XIX plan." 45 C.F.R. §248.3 (b)(4)(1977). Thus, by necessary inclusion, the 209(b) states were still subject to the deeming rules in effect in 1972.

Consequently, at all times since the implementation of Title XIX, regulations have been in effect which, explicitly or implicitly, required the 209(b) states to consider only income "actually available" to the applicant.[2/] Despite this prohibition, though, HHS did not stop states from deeming. Because that failure contradicts the language of the statute, and

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2/ Similar language has also applied to Puerto Rico, Guam, and the Virgin Islands. The SSI program did not apply to those jurisdictions, see Pub.L. No. 92-603, §303(b), 86 Stat. 1484 (1972); Califano v. Gautier Torres, 435 U.S. 1, 2 (1978), leaving them subject to requirements which had always been in effect. As plaintiff contends that the Medicaid statute, through 42 U.S.C. §1396a(a)(17), prohibits those states not tied to SSI eligibility to deem income available which is not in fact available, infra, at 24-79, these three island jurisdictions must be subject to the same rules as are the 209(b) states.

the explicit intent of Congress as expressed in the legislative history, plaintiff challenged the HHS action.

2. The Gray Panthers filed its complaint challenging the deeming rules on April 13, 1978 (J.A.9a). The district court found the statutory argument dispositive, and did not reach plaintiff's constitutional contentions. 461 F.Supp., at 321 n.3 (Pet.App. 27a n.3).[3/] The court acknowledged the statutory directive that the Secretary must prescribe the standards for determining what income and resources are "available", 42 U.S.C. §1396a(a)(17)(B), but held that that obligation did

> "not allow the Secretary to determine in a wholesale fashion what should be available to the applicant. ... [T]he phrase 'determined in accordance with standards prescribed by the Secretary' in clause (B) was not intended to remove the

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3/ Prior to the decision, the challenged regulations were rewritten and recodified, but with no "substantive" or "policy" changes. 43 Fed.Reg. 45176 (1978). The parties stipulated that the alteration represented no change in the effect of the regulations (J.A. 28a).

> requirement that only 'actually available' income and resources would be considered." 461 F.Supp., at 322 (Pet.App. 28a) (emphasis supplied; footnote omitted).

Furthermore, the court rejected defendants' contention that clause (17)(D), which allows states only to utilize financial responsibility laws directed at spouses and parents, led to a different result. "While [(D)] may allow a state to enforce its financial responsibility laws against a spouse or parent, this subpart does not suggest that the amount of contribution from that person should be a deemed amount." Id., at 322 n.5 (id., at 28a n.5) (emphasis in original). The court concluded that "the deeming procedure violates the Medicaid statute, and, therefore, is invalid." Id., at 323 (id., at 30a).

The orders issued in accordance with the decision (Pet.App. 31a, 33a) required defendants to rescind the offending regulations, "to require all relevant jurisdictions to cease deeming of income for any length of time between institutionalized Medicaid recipients or applicants

and their spouses," and to "promptly" implement new regulations.

In May, 1979, after defendants' motions for a stay to the district court and to the court of appeals had been denied, defendants issued orders to the affected jurisdictions to cease deeming. See CCH Medicare & Medicaid Guide, ¶14, 311, at p. 6195-3; 45 Fed.Reg. 82254 (1980); 44 Fed.Reg. 66855 (1979). Clarification of these orders was sent out by the Health Care Financing Administration on August 7, 1979. (J.A. 30a). Defendants published proposed regulations on November 21, 1979, nearly a year after the district court decision. 44 Fed.Reg. 66855. These proposed regulations complied with the statute by requiring states to "consider only the income in fact contributed by the spouse to the individual." 42 C.F.R. §§435.734(b), 436.711(b), 436.821(b), proposed at 44 Fed.Reg. 66856. Although these proposed regulations were apparently put in final form, see 45 Fed.Reg. 82255 (1980), they were never promulgated.

On July 29, 1980, the court of appeals affirmed. In the opinion, Judge Wright,

joined by Judge Markey (sitting by designation), analyzed defendants' arguments that the SSI statute required deeming in the 209(b) states. Recognizing that that requirement in the SSI statute was for reasons unrelated to the purpose of Medicaid deeming, 629 F.2d, at 184 (Pet.App. 7a-8a), the court held that it was probably appropriate to require limited Medicaid deeming in the SSI states,

> "[b]ut it does not reflect a decision by Congress that 'deeming' -- for six months or for any period of time -- is necessarily an appropriate practice in the 209(b) jurisdictions that are the subject of this case .... [T]here is no required federal statutory 'deeming' in the 209(b) jurisdictions ...." Id., at 184 (id., at 8a) (footnote omitted).

The court also rejected the Secretary's argument, offered below but not to this Court, that "enactment of the 209(b) option ... amounted to a specific congressional approval of [the 1972] criteria .... Congress was not expressing its view that 'deeming,' as then practiced in state Medicaid programs, was consistent with the requirements of the

Medicaid statute." Id., at 184-185 (id., at 9a).

The court evaluated the legislative history behind the "availability" requirement and noted two significant policy factors which militate against deeming when spouses are separated by institutionalization. First, separation destroys the single economic unit, so that "'deeming' no longer accurately reflects the economic norm." Id., at 185 (id., at 11a). Secondly, the court pointed to the statute's goal of "ensur[ing] that governmental regulation does not needlessly disrupt people's lives." Id., at 186 (id., at 11a). Deeming between spouses separated by institutionalization has exactly that result: "In contrast with the ordinary situation of cohabiting spouses, institutionalized individuals and their husbands or wives are particularly vulnerable to the disruptive forces that can be exerted by governmental regulations." Id., at 186 (id., at 11a).

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The court of appeals did recognize that it was the "primary responsibility" of the Secretary to determine the propriety of deeming in given situation. But that "determination ... must proceed within the framework established by the Medicaid statute." Id., at 186 (id., at 12a). The Secretary was therefore ordered to prepare new regulations which "consider those policy concerns ...."

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Id., at 186 (id., at 12a).

Dissenting in part, Judge MacKinnon viewed the majority decision as failing to provide "meaningful guidance for the Secretary to reevaluate her regulations." Id., at 188 (id., at 16a). He found the challenged regulations not to be arbitrary or capricious, and therefore would have upheld them. Id., at 189 (id., at 17a).

The case was remanded to the Secretary, with explicit instruction from the court of appeals that she promulgate new regulations "without delay". Id., at 187 (id., at 13a). Upon motion of plaintiff, the district court established a schedule for publication of those regulations (J.A. 33a). They were published in proposed form on October 30, 1980 (45 Fed. Reg. 71821), and in final form on December 15, 1980 (45 Fed.Reg. 82254), effective that date.

The new regulations do not entirely prohibit deeming. Rather, they establish the rules used in the SSI states as the most restrictive which a state

may use.[4/] The states are also permitted, however, to use more liberal deeming rules, and may decide not to deem at all. 42 C.F.R. §§435.734(b), 436.711(b), 436.821(b), as published at 45 Fed.Reg. 82259 (1980). Moreover, in the analysis preceding the new regulations, the Secretary has set out the significant considerations which argue against deeming; the Secretary's overriding concern is "to adopt policies that are in the best interest of program beneficiaries." 45 Fed.Reg. 82256 (1980).

Thus, two years after the district court made its initial ruling in this case, defendants finally promulgated and published regulations which substantially

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4/ Those rules require pooling of income for eligibility purposes for one month and six months after the spouse enters the institution, the length of the period depending on whether the non-institutionalized spouse is an eligible spouse. See 42 C.F.R. §435.723(c), (d) (Pet.App. 37a).

limit the challenged deeming policy.[5/] Since at least May, 1979, however, when defendants notified the affected jurisdictions of the district court decision, income deeming has not been permitted in the 209(b) and island jurisdictions. The decision in this case will therefore determine whether those jurisdictions, and others which may later opt for 209(b) status, will be permitted to return to a policy of deeming for indefinite periods and in unlimited amounts.

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5/ In the meantime, the federal court in Utah also held the HHS deeming regulations invalid. Allen v. Califano, No. 78-0212 (D.Utah, Aug. 23, 1979), appeal pending No. 79-2167 (10th Cir.). Both that court and the Tenth Circuit denied defendants' motions for a stay of the order, but Mr. Justice White recently granted that request. Schweiker v. Allen, No. A-783 (March 19, 1981). The Tenth Circuit has now lifted its stay of further appellate proceedings. (March 27, 1981)

SUMMARY OF ARGUMENT

I. Despite the recognized complexity of the Medicaid statute, the issue here -- the propriety of income "deeming" -- presents a comprehensible question. That question is whether the statute permits states to conclusively presume that income is available from an individual to his or her spouse in a nursing home without regard to whether it is in fact available.

Defendants contend that the case should be reviewed under the standard set out in Batterton v. Francis, 432 U.S. 416 (1977). Even if that is the appropriate standard, however, the challenged procedure is still impermissible, as it directly contradicts congressional intent and the purpose of the statute.

A. The "209(b) option", 42 U.S.C. §1396a(f), was established by Congress to permit those states which selected it to use different financial conditions for determining the Medicaid eligibility of the aged, blind and disabled than are required under the general rule tying

Medicaid eligibility to SSI eligibility. 42 U.S.C. §1396a(a)(10)(A). Specifically, so-called "209(b) states" are allowed to apply any of their Medicaid eligibility rules validly in effect on January 1, 1972. As the option did not free states from statutory requirements other than the tie-in to SSI eligibility, a state may only deem if that is consistent with 42 U.S.C. §1396a(a)(17), which has been in effect since Medicaid was introduced and which describes the financial conditions of eligibility.

B. Subsection (17) sets out one specific and three general requirements. Clauses (B) and (C) specify that only available income may be considered and that it must be reasonably evaluated. Clause (D) permits states to apply their financial responsibility laws to spouses, but does not, as defendants urge, allow a state merely to assume that that support is or will be provided.

C. Congress expressly stated in the legislative history that only "actually available" income could be counted, and that the statute was designed so that

states would not assume income available which was not "in fact" available. Congress thus sought to guarantee health care to the poor, regardless of the circumstances surrounding their indigency. A host of appellate and district courts have recognized this goal in invalidating state deeming practices.

Moreover, HHS itself, from the outset of the Medicaid program, has repeatedly stated that only "actually available" income should be considered. Although that language was eliminated from the 1977 revision of the regulations, it continued to be incorporated by reference. Statements in comparable contexts indicate that HHS recognizes the apparent meaning of "actual availability", despite its effort to disavow that meaning. And this Court has also forbidden states, in the AFDC program, from drawing conclusive presumptions of income availability; depriving, or threatening to deprive, the needy individual of assistance is not the appropriate means of enforcing the legal liability of another.

D. Clause (D) is not to the contrary. Its primary purpose is to prohibit states from applying relative responsibility laws to most relatives, but it exempts spouses from this prohibition. Still, by permitting states to employ spousal responsibility laws, Congress did not intend that they violate the requirement of actual availability in clause (B). (D) was intended as a limitation on familial responsibility, not an extension.

The lower courts have generally recognized that relative responsibility is not properly effected by a mere presumption of support, and HHS memoranda suggest the agency's recognition of the distinction between deeming and responsibility laws. Moreover, 42 U.S.C. §1396a(a)(25), and its implementing regulations, support the notion that, as a general rule, third-party liability is to be enforced through the state judicial process, not by reducing coverage on the assumption that support will be provided. The existence of a legal liability does not eliminate the requirement that only

actually available income be considered.

E. The policy considerations which motivated Congress, and which HHS has recently recognized, strongly support a prohibition against deeming. First, removal of one spouse to a nursing home destroys the single economic unit, which is the source for an assumption of support, and therefore for "deeming", between spouses living together. Secondly, deeming forces the non-institutionalized spouse to live below subsistence levels without any meaningful opportunity to dispute the state's decision, in contrast to the procedures available if responsibility laws are properly applied. Moreover, deeming can result in the denial of eligibility for the institutionalized spouse, or in eviction if the non-institutionalized spouse is unable or unwilling to pay the deemed amount. State officials often suggest divorce as a "solution", but that is a direct and insupportable intrusion on people's lives caused by the regulations.

In general, deeming exacerbates

an already difficult emotional situation through its uncompromising pressure on the non-institutionalized spouse. If that individual attempts to maintain a decent standard of living, he or she risks eviction of the other spouse. There is no opportunity to contest the state's presumption of availability. Congress specifically sought to prevent this unconscionable burden by its requirement of actual availability; it even cited, as an example of income which could not be counted, support payments from fathers which had not been in fact contributed. There is no indication that Congress meant to treat the legal liability of spouses any differently.

Congress established a procedure which fairly protects the interests of the applicant, the spouse, and the states. Deeming negates that carefully structured and balanced mechanism.

II. Defendants also assert that the SSI statute requires limited deeming in the 209(b) states. They contend that only SSI recipients are potentially

eligible for Medicaid in a 209(b) state, and that, therefore, 209(b) states must at least employ the SSI rules on income pooling.

Defendants' complicated analysis, however, ignores the language of the relevant provision. The 209(b) option explicitly releases states from the link to the SSI eligibility conditions. It requires opting states to use their valid January, 1972 rules, but nowhere states or implies that eligibility is available only to SSI recipients. The provision is flexible, and permits states to set their own financial eligibility conditions, subject only to the requirement that they not be more restrictive than those in effect in January, 1972.

That Congress intended the 209(b) option to be a flexible procedure is apparent from its insertion of a "spenddown" requirement for determining categorical eligibility. This is the most liberal of all Medicaid provisions, and is not required in the SSI states. Moreover, the spenddown requirement

demonstrates conclusively that Congress was not limiting eligibility in 209(b) states to SSI eligibles; many non-cash recipient individuals are categorically eligible in 209(b) states, as even defendants ultimately admit. And Congress recognized this necessary result by specifically defining all eligible Medicaid recipients in those 209(b) states without medically needy programs as categorically eligible.

Furthermore, the SSI provisions which defendants seek to impose in 209(b) states for determining Medicaid eligibility was not developed with the concepts of availability or deeming in mind. Rather, it was a fraud-control measure, designed to discourage spouses from voluntarily separating in order to obtain higher total SSI cash benefits. It bears no relationship to Medicaid or to deeming, and ignores the factors which militate against deeming for spouses involuntarily separated because one must enter a nursing home. Indeed, Congress has decided to treat a non-institutionalized spouse as an individual

for purposes of calculating the amount of the SSI entitlement, thus further recognizing the special nature of separations caused by institutionalization.

There is no legal basis for imposing the SSI income pooling requirements on spouses separated by institutionalization in 209(b) states.

A R G U M E N T

I. FEDERAL REGULATIONS PERMITTING STATES TO COUNT INCOME AS AVAILABLE TO AN INSTITUTIONALIZED SPOUSE, WHEN IT IS NOT IN FACT AVAILABLE, VIOLATE THE MEDICAID STATUTE

Judge Friendly has termed the Social Security Act and its regulations "almost unintelligible to the uninitiated." Friedman v. Berger, 547 F.2d 724, 727 n.7 (2d Cir. 1976), cert. denied 430 U.S. 984 (1977). Other judges have been equally uncharitable. One called the Medicaid statute "an aggravated assault on the English language, resistant to attempts to understand it." Friedman v. Berger, 409 F.Supp. 1225, 1225-1226 (S.D.N.Y.), aff'd 547 F.2d 724 (2d Cir. 1976), cert. denied 430 U.S. 984 (1977). Another

described the implementing regulations as "so drawn that they have created a Serbonian bog from which the agencies seemingly are unable to extricate themselves." Feld v. Berger, 424 F.Supp. 1356, 1357 (S.D.N.Y. 1976). HHS has itself admitted to the swamplike terrain of Medicaid in general and deeming in particular: "Medicaid eligibility criteria are the most technically complex of any Federal assistance program; regulations addressing it, unfortunately, are necessarily complex." 42 Fed.Reg. 2685 (1977).

A cursory reading of defendants' opening brief to this Court may suggest that the above complaints are understatements. Indeed, the government seems to suggest by implication that this area is so complex, so fraught with confusing mixtures between various parts of the Social Security Act, that the only rational recourse for a court is to defer to the agency. Who else, the government appears to ask, is in a position even to make a stab at the correct implementation

of the relevant provisions?

By any standard, the Medicaid statute is not susceptible to a simple or simplistic analysis. But, the government's approach to the particular issue of this case is considerably more complicated and convoluted than is necessary. Shorn of much that is irrelevant or only marginally related, this case presents a comprehensible question: whether Congress intended that, in counting the income of a Medicaid applicant, a state may merely assume that amounts derived by use of an arbitrary formula are available from the spouse of the institutionalized applicant regardless of whether in fact those amounts are made available. It is plaintiff's position that the statute, as supported by the legislative history, and by HHS' own previous interpretations, specifically forbids such assumptions, and that therefore regulations which allow income to be imputed from one individual to another, without proof of actual contribution, are inconsistent with the Medicaid statute.

In comments to its most recent regulations, HHS has defined deeming in these terms:

> "[I]n situations where one spouse is institutionalized, [deeming permits states] to consider a portion of the income of one spouse as available to the other spouse, whether or not the income is actually contributed. Thus, a State is able to reduce in advance its Medicaid payment to an institution for the care of the spouse." 45 Fed.Reg. 82254 (1980).

The district court below similarly defined it, noting as well the arbitrary nature of the process: "This imputing of income on the basis of an arbitrary formula, without regard to the amount actually available to the institutionalized spouse, is commonly referred to as 'deeming'." 461 F.Supp., at 321 (Pet.App. 25a). Both the majority and the dissent in the court of appeals utilized similar definitions. 629 F.2d, at 183, 187 (Pet.App. 5a, 13a). The two basic premises of deeming, therefore, are that an amount unrelated to, and insufficient for, the actual needs of the non-institutionalized spouse is set aside for his or her use, with the

remainder deemed to the institutionalized spouse. That remainder is counted by the state as income of the institutionalized spouse for purposes of determining whether that individual is eligible for Medicaid, and, if so, the amount of benefits to be paid.[6/] Thus, deeming can lead either to a denial of eligibility, or to the institution receiving an insufficient amount to cover the cost of care, with eviction from the nursing home as the ultimate result.

In the SSI states, a form of this practice is permitted, but on a limited basis. When only one spouse is eligible, the pooling of their incomes must cease after the first month of institutionalization; when both are eligible, the income must be pooled for the first six months of institutionalization. 42 C.F.R.

6/ A Medicaid recipient receives no cash benefits. Instead, the provider (nursing home, doctor, pharmacist, etc.) bills the state agency. The agency then pays the difference between the cost of care and the amount of income for which the recipient is responsible.

§435.723(c), (d) (1979); see 629 F.2d, at 183 (Pet.App. 5a). HHS derives this rule from the relationship between the Medicaid and SSI statutes, as income pooling for couples is built into SSI eligibility determinations. See 42 C.F.R. §435.120; 42 Fed.Reg. 2685 (1977); see also Herweg v. Ray, 619 F.2d 1265, 1285-1287 (8th Cir. 1980) (McMillian, J.), pet. for cert. pending No. 80-60 (filed July 14, 1980). As there is no similar linkage between the 209(b) states and the SSI statute, however, those rules are not relevant to this case. See infra, at 79-96.

Defendants offer two distinct arguments to support their contention that deeming is required under the Medicaid statute in the jurisdictions here at issue. First, they contend that 42 U.S.C. §1396a(a)(17) permits unlimited deeming, subject to the requirement that the standards be no more restrictive than those in effect on January 1, 1972. Pet. Br. 17-27. Secondly, defendants argue that without regard to the explicit requirements and limitations of the

Medicaid statute, the relationship between that statute and the SSI statute requires a 209(b) state, at a minimum, to utilize the SSI rules on income pooling. Id., at 27-49. Although defendants devote the bulk of their discussion to the latter argument, the former is the real issue of this case. The question for resolution is whether the appropriate section of the Medicaid statute permits states to deem indefinitely. The issue here is the propriety of deeming in states which have specifically selected not to be bound by SSI criteria.

Defendants contend that the appropriate standard for review of the challenged regulations is that set out in Batterton v. Francis, 432 U.S. 416 (1977). Since it is the Secretary to whom Congress has entrusted the task of establishing the standards applicable to determining what income is available, 42 U.S.C. §1396a(a)(17)(B), defendants conclude that the Batterton approach is appropriate. The court below applied that standard, 629 F.2d, at 183 (Pet.App.

6a-7a), but still found the Secretary's actions unpersuasive in light of the statute's requirements.

The Batterton standard, however, is not necessarily applicable to this case. Judge Ross, writing for half of the Eighth Circuit, evaluated the same language, and concluded that it did not entrust the Secretary with the legislative obligation described in Batterton. Herweg v. Ray, supra, 619 F.2d, at 1272 n.4 (Ross, J.).[7/]

Moreover, even assuming the applicability of Batterton to this case, it does not automatically validate the actions of the Secretary. The Secretary is still

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7/ "[I]n Batterton Congress had given HEW the specific task of defining one term, 'unemployment,' rather than the general delegation of establishing standards which are 'consistent with the objectives of this subchapter.' §1396a(a)(17)(A).... In view of the difference in statutory mandate, we do not believe the standard of review under Batterton applicable to this case." Herweg v. Ray, supra, 619 F.2d, at 1272 n.4 (emphasis in original); contra Herweg v. Ray, supra, 619 F.2d, at 1276-1277 (McMillian, J.).

forbidden to implement regulations which are inconsistent with the statute. This Court must determine "that the Secretary's approach ... is not contrary to the purpose of the statute." Batterton v. Francis, supra, 432 U.S., at 431. In that effort, as the court of appeals determined, the Secretary failed. While establishing broad rules for evaluating "available" income, the Secretary neglected one of the most crucial and recurring situations, one which represents a significant and decided exception to the general rule that spouses' incomes are equally available to each other. It is in this failure, in neglecting to recognize the different policy considerations which attach and which are specifically discussed in the statute's legislative history, that the Secretary has negated the intent of Congress. Even under the most demanding standard, the Secretary is still not free from the obligation to ensure that the regulations implement the intent of Congress. The agency must consider "the relevant factors". Citizens to Preserve Overton

Park, Inc. v. Volpe, 401 U.S. 402, 414 (1971).

The Secretary is required to determine when deeming is permitted and when not permitted. The challenged regulations did not make that distinction. The Secretary's introduction to the new regulations demonstrates the significance of the factors relevant to this issue, see 45 Fed.Reg. 82254 (1980); the Secretary had previously ignored those factors, choosing instead to treat all couples the same, regardless of whether they were still living together and with no apparent recognition of the explicit purposes of the statute as set out in the legislative history. "[I]n order to be valid, [regulations] must be consistent with the statute under which they are promulgated." U.S. v. Larionoff, 431 U.S. 864, 873 (1977). That requirement is the key to an understanding of the Secretary's failing in this instance, for the challenged regulations are inconsistent with the statute.

> "The power of an administrative officer ... to prescribe rules

> and regulations ... is ... the power to adopt regulations to carry into effect the will of Congress as expressed by the statute. A regulation which does not do this, but operates to create a rule out of harmony with the statute, is a mere nullity." Manhattan General Equipment Co. v. Commissioner of Internal Revenue, 297 U.S. 129, 134 (1936) (citations omitted).

Regulations permitting states to count as available income which, in fact, is not available, directly contradict the purpose of the statute and the intent of Congress.

A. The 209(b) option (42 U.S.C. §1396a(f)

The 209(b) option, section 1902(f) of the Social Security Act, 42 U.S.C. §1396 a(f) (Pet.App. 36a), is framed in the negative. It permits a state which does not meet the requirements for providing Medicaid pursuant to the SSI rules to provide Medicaid pursuant to another set of rules. The release from the SSI rules is established with these words: "... no State not eligible to participate in the State plan program established under

subchapter XVI of this chapter [SSI] ...." The tie-in, or linkage, to the SSI program is established by 42 U.S.C. §1396a (a)(10)(A), which requires all states to provide Medicaid to all SSI recipients. See 629 F.2d, at 182 (Pet.App. 3a). Thus, if a state does not comply with section 1396a(a)(10)(A), and is therefore "not eligible to participate in the State plan program established under subchapter XVI of this chapter," 42 U.S.C. §1396a(f), it need not generally provide Medicaid to the aged, blind and disabled.

Of course, there is a significant proviso. The state must cover as eligible any aged, blind or disabled individual if it "would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this subchapter [XIX] and in effect on January 1, 1972, been in effect in such month ...."

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42 U.S.C. §1396a(f).[8/]

The basic premise, therefore, of the 209(b) provision is that the SSI criteria are not applicable; instead, the Medicaid rules in effect in 1972 control. A state is therefore only required to provide Medicaid to those individuals who would have been eligible in 1972 -- subject to the deductions from gross income. Furthermore, the 1972 rules must themselves have been valid, for the 209(b) option was not intended to forever legitimize all rules which a state may have employed in 1972. See 629 F.2d, at 185 (Pet.App. 9a); Norman v. St. Clair, 610 F.2d 1228, 1235 (5th Cir. 1980), pet. for cert. pending sub nom. Schweiker v. Norman, No. 80-498 (filed Sept. 27, 1980); Winter v. Trainor, CCH Medicare & Medicaid Guide ¶28,151 at p. 10,599 (N.D.Ill. 1977). Rather, it was intended to permit states to utilize 1972 rules and standards

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8/ The remainder of the provision requires the exclusion of certain income and the "spenddown" for incurred medical expenses, and defines the categorically and medically needy in 209(b) states. See infra, at 79-96.

appropriately implemented under the Medicaid statute.[9/] Consequently, if deeming was invalid in 1972, it has not been rendered legal by the 209(b) option. Norman v. St. Clair, supra, 610 F.2d, at 1235.

Section 1396a(f) thus necessarily incorporates section 1396a(a)(17), which provides the financial eligibility standards for Medicaid. The 209(b) option does free a state from compliance with the SSI statute, but the state remains subject to the Medicaid rules, including those established by subparagraph (17). Defendants apparently accept this

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9/ Apparently retreating from their position below, see 629 F.2d, at 184 (Pet.App. 9a), defendants no longer disagree with this analysis: "If the eligibility criteria of a 209(b) state's 1972 Medicaid plan are valid ...." Pet. Br. 13 (emphasis supplied); see also id., at 47.

analysis,[10] and their discussion of §1396a(a)(17) indicates an understanding that that subsection -- not (10)(A) or the SSI statute -- must determine whether deeming is permitted. In short, whatever else is accomplished with section 1396a(f), it does not free a state from compliance with subsection (17). See, e.g., Hanke v. Nyhus, 470 F.Supp. 742, 745 (D. Minn. 1979). Resolution of this case therefore depends on an analysis of subsection (17).

B. Overview of 42 U.S.C. §1396a(a)(17)

Subsection (17) requires a state plan to

"include reasonable standards ...

10/ "[T]he purpose and effect of the 209(b) option is solely to provide a partial exemption from the requirements of 42 U.S.C. §1396a(a)(10)(A). A state that exercises the option cannot be required to cover SSI benefit recipients, unless those individuals would have been eligible for Medicaid benefits under the state's 1972 Medicaid plan. All of the other requirements of the Medicaid statute are fully operative." Pet.Br. 43 (emphasis supplied); see also id., at 11.

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> for determining eligibility and the extent of medical assistance which (A) are consistent with the objectives of [title XIX], (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient ... in determining his eligibility for such aid, assistance or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse ...."

The statute thus makes four demands of the states. First, they must not violate the overriding purpose of Medicaid, which is to provide health care to the indigent. 42 U.S.C. §1396(1); see O'Bannon v. Town Court Nursing Center, -- U.S. --, -- n.2, 100 S.Ct. 2467, 2470 n.2 (1980). Secondly, they must count only available income and resources. Thirdly, the evaluation of income and resources must be reasonable. And, finally, regardless of which relatives are subject to financial responsibility laws in a given state, the state

may only apply those applicable to spouses.

Defendants interpret this provision with two general approaches. First, they contend that "available ... could not have been intended to exclude consideration of all income not in the applicant's hands." Pet.Br. 20. Secondly, they assert that clause (D) "obviously contemplates that the income of an applicant's spouse may be considered 'available' in determining the applicant's eligibility for medical assistance ...." Id., at 18. This analysis, however, is directly at odds with the provision as a whole, with the legislative history, and even with defendants' own previous explicit guidelines and regulations. Had the word "available" appeared in a vacuum, defendants' interpretation might have been acceptable. But they ignore overwhelming authority in favor of a semantically impossible proposition: that "available" income can include income which is not available.

Subsection (17) must be read as a

continuum, with each part reflecting on the rest. (A) offers the general guideline: that Medicaid is designed to ensure the provision of medical assistance to those unable to pay for it. The remaining parts of (17) should be evaluated in light of that general premise. (B) requires states to evaluate an individual's financial position only in terms of the income and assets which that individual has. Tempering the temptation to read "available" so broadly that it would lose its meaning is clause (C), which demands a "reasonable" evaluation of income and resource. Whatever flexibility derives from "available" must be countered by a determination that that flexibility is not unreasonable. Finally, clause (D) does not operate as an exception to the rest of the subsection. Its major thrust is to forbid states from applying relative responsibility laws to relatives other than spouses. That states may take into account the financial responsibility of spouses, however, does not permit them to assume income available which is not available; it merely permits them to

apply those laws as usual.

C. Clauses (B) and (C): availability in fact

The availability requirement is discussed in detail in the legislative history. Both the Report of the Senate Finance Committee and that of the House Ways and Means Committee flesh out its meaning in unequivocal terms. The reports state an explicit purpose, one which is seemingly subject to only one interpretation:

> "Another provision is included that requires States to take into account only such income and resources as ... are actually available to the applicant or recipient .... Income and resources taken into account, furthermore, must be reasonably evaluated by the States. These provisions are designed so that the States will not assume the availability of income which may not, in fact, be available ...." S.Rep.No. 404, 89th Cong., 1st Sess. (1965), reprinted at [1965] U.S. Code Cong. & Admin. News, 1943, 2018; H.Rep.No. 213, 89th Cong., 1st Sess., 67 (1965) (emphasis supplied).

Even if the words "actually available" could be interpreted to allow states to

consider some portion of a separated spouse's income which was not contributed to the other spouse's care, the last sentence leaves no doubt as to Congress' express intent: "available" income cannot include income which is not in fact available. When a spouse fails to make a contribution, that income is not in fact available. Defendants have never indicated how this language could conceivably permit a state to count income not available to the applicant as if it were.

Congressional leaders echoed these explicit directives. Senator Ribicoff stated: "The bill would also require that only income and resources actually available to an applicant be considered in determining need ...." 111 Cong.Rec. 15804 (1965). Rep. Mills, in summarizing the statute for the House, made a similar observation: "No income can be imputed to an individual unless actually available ...." 111 Cong.Rec. 7216 (1965). The reports of the two committees repeated this prohibition against imputing income "to an individual unless actually

available." S.Rep.No. 404, supra, at 2018; H.Rep.No. 213, supra, at 10.

The starting point for analysis, therefore, is that Congress did not intend that an indigent individual be denied Medicaid merely because a state attributed income which falsely negated that poverty. Defendants' interpretation not only repudiates the explicit statements in the legislative history, but necessarily places the burden for receipt of medical assistance on the cooperation of an individual over whom the institutionalized spouse has no control. (B) and (C) were directed at the state's evaluation of the applicant's sitation, not at the state's rights with respect to the applicant's spouse.[11/] The legislative history explicitly requires the Secretary to develop regulations which will guarantee Medicaid for those with insufficient income to pay for their care. If that income is not in fact available to the applicant -- for whatever reasons -- Congress forbade its

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11/ Clause (D) is the vehicle for that effort. See infra, at 60-70.

consideration.

Defendants' analysis of clauses (B) and (C) has been implicitly or explicitly rejected by a multitude of lower courts.[12/] All have recognized that it is unreasonable to interpret a provision requiring consideration of only actual contributions in a manner which specifically permits

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12/ Gray Panthers, 629 F.2d, at 185 (Pet.App. 10a), aff'g 461 F.Supp., at 322 (Pet.App. 28a-29a); Brown v. Stanton, 617 F.2d 1224, 1230 (7th Cir. 1980), pet. for cert. pending No. 79-1690 (filed April 25, 1980); Hanke v. Nyhus, supra, 470 F.Supp., at 746; Nursing Home Residents' Advisory Council, 470 F.Supp. 747, 751-752 (D. Minn. 1979); Krygier v. Buscaglia, CCH Medicare & Medicaid Guide, ¶29,761, at p. 10,460 (W.D.N.Y. 1979); Foard v. Gibson, CCH Medicare & Medicaid Guide ¶29,679, at p. 10,145 (W.D.N.C. 1979); Rubin v. Creasy, CCH Medicare & Medicaid Guide ¶29,678, at p. 10,143 (S.D.Ohio 1979); Allen v. Califano, supra, Slip Op., at 2; Manfredi v. Maher, 435 F.Supp. 1106, 1113 (D.Conn. 1977); Burns v. Vowell, 424 F. Supp. 1135, 1140-1141 (S.D.Tex. 1976); Franssen v. Juras, 406 F.Supp. 1375, 1378 (D.Ore. 1975); see also McLaughlin v. Wohlgemuth, 398 F.Supp. 269, 276 (E.D.Pa. 1975), vac't and rem'd on other grounds 535 F.2d 251 (3d Cir. 1976) (similar situation involving AFDC statute analyzed in same way).

states to include income (or resources) which are not actually available.

> "[I]t is unreasonable ... for a state to assess the income of two persons on the theory that they maintain a single household, when it is a recognized fact that one member of that couple is confined to a long-term medical care facility. Such an assumption flies in the fact of simple, economic reality ...." Manfredi v. Maher, supra, 435 F.Supp., at 1113-1114 (footnote omitted).

Ironically, HHS formerly interpreted the statute in exactly this manner -- at least in writing. Its original explanation of these sections does not differ significantly from that which it employed until 1977. The initial dictates to the states appeared in HEW's Handbook of Public Assistance Administration, Supplement D.[13/]

13/ The Handbook was replaced by regulations in 1970. See 35 Fed. Reg. 8780 (1970); 36 Fed.Reg. 3860 (1971). Defendants acknowledge that the Handbook imposed restrictions on the states in the same manner as do regulations. Pet.Br. 26-27 n.14; see Response to Int. 16(a) (R., Joint App. in Court of Appeals, 45); see also Rosado v. Wyman, 397 U.S. 397, 415 (1970); King v. Smith, 392 U.S. 309, 317 (1968).

Thus, shortly after the statute became effective, HHS required states to evaluate financial eligibility in the identical fashion which Congress expressed in the legislative history:

> "Income and resources are realistically evaluated and are not assumed to be available from sources from which payments are not in fact received .... Available income and resources are income and resources which are 'in hand' or under the control of the individual ...." Handbook, Supp. D, §D-4230(4); see also id., §§D-4220(A)(4), (B)(3).

Again, it is difficult to interpret that language to permit states to include income which is not included; that is, however, excatly what states were doing. HHS never questioned states' deeming policies until after the implementation of SSI in 1974, despite this seemingly explicit language in the agency's regulations forbidding such action. Response to Request for Admission 15(c) (R., Joint App. in Court of Appeals, 25, 30); Defendants' Agreement with Plaintiff's Findings of Fact Not in Dispute No. 3 /

(R., Joint App. in Court of Appeals, 34, 39).[14/]

The requirement of "actual availability" was first codified in 1969. Like the Handbook, the regulations required states to

> "Provide that only such income and resources as are actually available will be considered; that income and resources will be reasonably evaluated; and that such income and resources will be considered as will be 'in hand' with a period, preferably of not more than 3 months ...." 45 C.F.R. §248.21(a)(4)(1970), as added in 34 Fed.Reg. 1320, 1321 (1969).

14/ Defendants' statement that state deeming practices were undertaken "[w]ith the approval of the Secretary of Health, Education and Welfare", Pet.Br. 3, is somewhat questionable. While HEW never moved to stop states from deeming, that "approval" appears to violate its own explicit prohibition against deeming. Either HEW was acting inconsistently with respect to its own regulations, or its regulations were interpreted in a manner directly contrary to their apparent meaning. In either event, the agency's behavior indicates a schizophrenic approach.

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Changes in location and codification were made over the years,[15] but the requirement that only actually available income be considered remained explicitly in the regulations until April 13, 1977.

These requirements reflected an apparent recognition that deeming should not be permitted between spouses separated by institutionalization. While HHS was not forcing the states to comply, it at least appeared to comprehend that these rules flowed necessarily from the statute and its legislative history.

The "new" regulations were first proposed in late 1975, more than 3 years after SSI was passed and two years after it went into effect. Their avowed major purpose was to impose the requirements of

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15/ See 45 C.F.R. §§248.21(a)(2)(i), 248.21(a)(3)(iv) (1972), recodified at 36 Fed.Reg. 3860, 3871 (1971); 45 C.F.R. §§248.3(b)(1), 248.21(a)(2)(i), 248.3(c)(4), 248.21(a)(3)(iv) (1974) (different codification for Puerto Rico, Guam, and the Virgin Islands, as opposed to all others), recodified at 39 Fed.Reg. 9512, 9516-9518 (1974).

the SSI statute on the "SSI states". See 40 Fed.Reg. 60074 (1975). At the same time, the proposed regulations purported to "clarify" the "actually available" language: "The reference to 'actually available' income and resources has inhibited proper imposition of relative responsibility provisions in eligibility determinations, in that support, while available, may not in fact be provided, thus creating an ambiguity as to whether it is 'actually' available." Ibid. Thus, while HHS admitted that the institutionalized spouse did not control the income, it rationalized the violation of explicit congressional intent and statement by allowing states to consider "support" which should have been provided (pursuant to relative responsibility laws) as if it were income which was in fact available. The "actually available" language was maintained, but the agency permitted 209(b) states to assume income available just as they always had. See proposed 45 C.F.R. §§248.3(b)(1), (4), at 40 Fed. Reg. 60074-60075 (1975).

When published in final form more than

a year later, however, this approach was scrapped. 42 Fed.Reg. 2684 (1977). Apparently deciding that further inclusion of the "actually available" language would only provide a basis for challenges to state deeming practices, the agency devised a detour around that language:

> "(A) State plan must:
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> (1) General. Provide that only such income and resources as are considered available under the provisions of this section may be considered ...." 45 C.F.R. §248.3(b)(1), as amended at 42 Fed.Reg. 2686 (1977).16/

It then set out the alternative approaches available depending on which option a state had chosen. Still managing not to use the expression "actually available", HHS offered this directive to the 209(b) states:

> "Provide that the available income and resources of spouses of aged, blind, or disabled applicants or recipients, ...

16/ It did not, however, alter the requirements "that income and resources will be reasonably evaluated" and that only income "in hand" be considered. 45 C.F.R. §§248.3(b)(1), 248.3(c)(4).

> must be considered as available in a manner identical to or more extensive than the manner in which such relatives' incomes and resources must be considered [in the SSI states]. However, such consideration of income and resources may not be more restrictive than that included in the State's January 1972 title XIX plan." 45 C.F.R. §248.3(b)(4), as added at 42 Fed.Reg. 2687 (1977).17/

HHS thus fell back on the language of the 209(b) provision, which necessarily required states to comply with federal law in effect in 1972. Of course, in 1972, the "actually available" language was a prominent part of the regulations, so that whatever the states may have actually been doing in 1972, they were subject to a requirement that prohibited them from considering any but "actually available" income. While the agency thus neatly disposed of language which was

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17/ A similar approach was utilized for Puerto Rico, Guam, and the Virgin Islands. See 42 Fed.Reg. 2687, 2688 (1977).

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effective in repudiating deeming,[18] it could not avoid the necessary implications of the 209(b) provision, nor the Medicaid statute and its legislative history.

Thus, since 1977 there has been no explicit regulatory requirement of "actual availability".[19] That does not, however, alter the obligation of HHS to enforce the statutory requirements. The statute precludes assumptions of income. That prohibition was specifically effected through regulatory requirements. And HHS cannot explain how its previous regulatory language could conceivably have permitted deeming. Indeed, it has indicated that those regulations' apparent meaning is the correct one.

18/ See, e.g., Franssen v. Juras, supra, 406 F.Supp., at 1378.

19/ The regulations were later renumbered, but with no change in wording. They became 42 C.F.R. §§448.3(b)(1), (4) (1977). 42 Fed.Reg. 52827 (1977). It was these regulations which were specifically challenged. As previously noted, supra, at 7, these were later altered in both wording and codification, but with no change in meaning.

In the AFDC program, for instance, the question of eligibility and amount of assistance must be determined with regard to support from the absent parent. HHS has promulgated a regulation which guarantees that recipients will not be punished for the failure of responsible individuals to make support payments. In so doing, the agency indicates conclusively that "actually available" does not include income which should be available: states cannot merely assume that support will be provided. The regulation states: "Whether or not the [child] support payments are received regularly, the agency does not delay or reduce public assistance payments on the basis of assumed support which is not actually available." 45 C.F.R. §233.20(a)(3)(v)(1978). Presumably, the import of this section is that "assumed support" can only be counted when it is in fact contributed. If HHS regulations are consistent, "actually available" must mean the same for children as for spouses.

Moreover, in comments to the regulations which were published pursuant to

the decision below, HHS described the treatment of support payments that are in fact made from one spouse to the other: "[T]his payment would always be considered in eligibility determinations since it is 'in-hand' (i.e., actually contributed)." 45 Fed.Reg. 82257 (1980) (emphasis supplied). HHS thus equates income which is in hand with that which is actually contributed. This seemingly obvious interpretation is significant, however, because HHS has repeatedly contended that states were not limited to counting only actually contributed income, but could also count income which was merely deemed available. This position was taken, of course, without regard for the fact that HHS' own regulations consistently required consideration of only "in-hand" income.[20/]

20/ That "available" means what it appears to mean is reflected in the congressional recognition that deeming is an exception to availability. Thus, in certain situations involving SSI, Congress explicitly negates the general rule of availability in favor of deeming. For

(cont. p. 56)

The HHS position on clauses (B) and (C) of subsection (17) has been to disavow its own regulations, which appear, both implicitly and explicitly, to have forbidden states from presuming the availability of income. In either its failure to act on its own regulations, or its effort to change the meaning of those regulations without explanation or rationale, HHS has acted without regard for the explicit dictates of Congress and the significant policy considerations behind those directives.[21/]

20/ (cont.)

instance, in determining the eligibility of an individual living with an ineligible spouse, Congress requires that "such individual's income and resources shall be deemed to include any income and resources of such spouse, whether or not available to such individual ...." 42 U.S.C. §1382c(f)(1)(emphasis supplied); see also id., §1382c(f)(2).

21/ Defendants claim that their deeming rules for the 209(b) states derive from "a careful analysis of the interlocking provisions of the Medicaid Act and [SSI] statute ...." Pet.Br. 11. Yet, when it eliminated the "actually available" language in the 1977 regulations

(cont. p. 57)

This Court, though, considered a similar issue in the AFDC context, and concluded that assumptions of support, without an actual contribution, are impermissible. In Lewis v. Martin, 397 U.S. 552 (1970) and Van Lare v. Hurley, 421 U.S. 338 (1975), the Court evaluated state practices which reduced AFDC benefits on the assumption that a lodger in the house or a man assuming the role of spouse ("MARS") was contributing to the recipient child's support. These policies were invalidated, for reasons substantially similar to those advanced by plaintiff.

In Van Lare, the Court recognized that this policy, while affecting the

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21/ (cont.)

which divided the SSI and 209(b) states, HHS did not analyze the significance of that change, or the policy factors militating against deeming. See 42 Fed.Reg. 2684-2685 (1977). While devoting considerable attention to the rationale for limiting deeming in the SSI states, HHS has ignored the impact of deeming and the significant legal arguments against it.

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intended beneficiaries, was directed at the lodger. This purpose was repudiated: "States may not seek to accomplish policies aimed at lodgers by depriving needy children of benefits." 421 U.S., at 348. Similarly, HHS and the states are here attempting to force a contribution from the non-institutionalized spouse by depriving the needy individual of benefits.[22/] In both situations, the individual for whom Congress designed the program is a pawn in the state's effort to force compliance by the non-beneficiary. This Court rejected the state procedure in Van Lare because of its assumption that the lodger contributed to the household "without any inquiry into whether in fact he does so." Id., at 346. The instant situation is no different.

22/ HHS recently acknowledged that deeming results in harm to the institutionalized spouse, whose behavior is not in question, while proper application of spousal support laws places the burden on the responsible party, the non-institutionalized spouse, whose refusal or inability to cooperate is the crux of the matter. 45 Fed.Reg. 82256 (1980).

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Lewis provides another relevant observation in a comparable context: "[T]he likelihood of the MARS contributing his own income to the children -- even if legally obligated to do so -- is sufficiently uncertain in the absence of marriage ties to prevent viewing him as a 'breadwinner' unless the bread is actually set on the table." 397 U.S., at 559. A similar analysis applies here. If the contribution has not in fact been made, then there is no basis to deprive the intended beneficiary of the assistance to which she is entitled. The need exists, regardless of why the contribution was not made. Children unsupported by a man-in-the-house are no less needy than those with no man there; similarly, an elderly, sick individual whose spouse does not make a demanded contribution is no less indigent because the state has determined that the contribution should be made. In both instances, the purpose of the statutes, to provide assistance to the impoverished, is subverted by bureaucratic assumptions which do not reflect reality.

Van Lare and Lewis are often distinguished from the issue of this case on two grounds. First, as the Fifth Circuit found dispositive, those cases involved individuals with no legal responsibility toward the applicants. Norman v. St. Clair, supra, 610 F.2d, at 1238-1239. Secondly, in the AFDC cases, the beneficiaries and adults were living together, necessarily sharing certain living expenses, such as shelter. By contrast, in this case, the spouses are separated. This factor, the dissolution of the "economy of scale", is a significant policy consideration, as even HHS ultimately recognized. See 45 Fed.Reg. 82256-82257 (1980). Before examining that issue, however, it is necessary to evaluate the significance of spousal responsibility in this context.

D. Clause (D): a limitation, not an extension

Defendants argue that (D) acts as an exception to the requirement of actual availability in (B). In effect, defendants contend that income which is subject to a support requirement --

regardless of whether any effort has been made to enforce that requirement -- is available to the applicant. This assumption that income potentially subject to a support order is available to the institutionalized spouse represents a legal fiction. It violates the express words and purpose of clause (B). Congress did not intend (D) to be an exception to (B), nor do the words of the provision support that interpretation. Spousal responsibility laws can be enforced, but they were never intended to be implemented by a bureaucratic methodology which bypasses state judicial processes.

As defendants note, one of Congress' concerns in replacing the limited Kerr-Mills medical assistance program was the disastrous effect that state responsibility laws were having on relatives of individuals requiring health care: the new statute "prohibits many of the sad practices such as relative responsibility tests which have plagued Kerr-Mills programs in the past." 111 Cong.Rec. 15813 (1965) (remarks of Sen. Hart). Thus, to relieve some of this burden, states were

specifically precluded from demanding contributions from relatives other than spouses and parents. At the same time, Congress noted that it was "proper to expect spouses to support each other .... Such requirements for support may reasonably include the payment by such relative, if able, for medical care." S.Rep.No. 404, supra, at 2018; H.Rep.No. 213, supra, at 68.

These concerns and explanations, however, nowhere indicate an intent that the appropriate method of enforcement was by deeming or assuming the availability of contributions. In one breath, Congress explicitly forbade states from making assumptions of availability. There is nothing to suggest that, in its next breath, Congress carved out a partial exception to that rule. The major thrust of clause (D) is not to impose obligations on families of beneficiaries, but to limit the obligations which would otherwise attach under state law. That provision adds nothing to the responsibility of spouses under state law; it merely notes that spouses remain subject to

whatever state laws are applicable. It does not expand the significance or meaning of those laws.[23/]

Nor does the legislative history suggest otherwise. Sen. Ribicoff, for instance, never indicated that states could, or were expected to, implement that provision by violating the express terms of clause (B). Instead, he merely noted that the "bill would also require ... that contributions may be required only from spouses ...." 111 Cong.Rec. 15804 (1965). Similarly, Sen.McNamara noted that the purpose was to avoid the use of relative responsibility laws "which often served to deter otherwise qualified individuals from seeking help.

23/ "[42 U.S.C. §1396a(a)(17)(D)] is intended to authorize a state mechanism for enforcing financial responsibility of relatives, not to permit presumptions forbidden elsewhere in the statute." Fransen v. Juras, supra, 406 F.Supp., at 1379; see also Brown v. Stanton, supra, 617 F. 2d, at 1230; Gray Panthers v. Secretary, supra, 461 F.Supp., at 322 n.5 (Pet.App. 28a n.5); Manfredi v. Maher, supra, 435 F.Supp., at 1109 n.5; McLaughlin v. Wohlgemuth, supra, 398 F.Supp., at 278.

The new bill would limit the application of the family responsibility provision to the spouse, if any, of the applicant." Id., at 15876. The goal, then, was to liberalize the existing system, not to impose requirements which would result in the applicant spouse losing eligibility. There is no indication in the legislative history that Congress ever contemplated that clause (D) would expand the impact and effect of relative responsibility laws.

HHS itself has recognized that relative responsibility laws do not encompass deeming. In a "Report to Secretary Mathews", dated September 20, 1976, Robert Fulton, Administrator of the Social and Rehabilitation Service (SRS) of then-HEW,[24/] evaluated (B) and (D):

> "[C]lause (D) of Section 1902(a)(17) does not, in our view, have anything to do with the consideration

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24/ SRS preceded the Health Care Financing Administration (HCFA); both had responsibility within HHS to develop policies implementing the Medicaid statute. 42 Fed.Reg. 33071 (1977).

('deeming' or 'assumption') of income. Clause (B) of that section deals with that topic. Clause (D), on the other hand, is a Federal limitation on the ability of states to enact relative responsibility laws. In other words, a State cannot, consistent with the Medicaid statute, enact a law requiring adult children to contribute to the medical costs of their parents ....

Financial responsibility laws do not, in themselves, deal with the question of the availability of income. Even if the law requires a contribution, the question still must be asked whether that contribution has actually been made or, if not, under what circumstances it should be assumed to have been made ('deeming' or 'assumption' of income)."

In an August 12, 1976 memorandum to the Secretary, an "Information Paper on Deeming and Relative Responsibility" was attached to explain the various issues in the area and to support the regulations proposed the previous December which were published in final form the following January. The paper (known by HHS as the "Morrill Memo") makes these observations:

"Relative responsibility provisions are embodied in State law and consist of general statutory requirements that specified relatives contribute to the support of other specified relatives. These laws are enforced through either criminal or civil proceedings. In the context of public assistance programs, State relative responsibility laws are invoked after the fact of eligibility determination. States (under applicable statutory authority) may seek retroactive recoveries through the courts when required contributions are not made.

Deeming permits government in specified instances to assume that the income and resources of certain individuals are available to an applicant for the purpose of determining financial eligibility for public assistance. Deeming is grounded in Federal statutes and is implemented by regulations which specify general standards for the reasonable evaluation and treatment of deemed income. There is no necessary relationship between deeming provisions and relative responsibility, although the former has its roots in the latter." Summary (of Morrill Memo), at 1 (emphasis supplied)(R., Ex. to Joint App.

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in Court of Appeals, 2).[25/]

These internal memoranda indicate that HHS recognizes the limited nature of relative responsibility laws. They do not, of themselves, permit states to assume availability; their sole method of enforcement is via state "criminal or civil proceedings." In published documents as well, HHS has recognized the appropriate use of these state laws. Responding to criticism from the SSI states regarding its proposal to limit deeming in those states, HHS noted that they were not precluded "from enforcing laws to retroactively recoup from responsible relatives medical assistance expenditures paid by the State on behalf of eligible recipients." 42 Fed.Reg. 2685 (1977) (response to Comment 1); see also id., at 2686 (response to comment 6). A similar sentiment was expressed in comments to the most recent regulations,

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25/ The Memo adds, however, that "[d]eeming ... may be considered a form of relative responsibility." Morrill Memo, at 2 (R., Ex. to Joint App. in Court of Appeals, 6).

where deeming and relative responsibility laws were referred to as different "methods". 45 Fed.Reg. 82256 (1980).

This recognition of the limited applicability of responsibility provisions gains further support from Congress' requirement that, where possible and reasonable, states should obtain contributions from legally liable third parties. 42 U.S.C. §1396a(a)(25). The regulations implementing that section indicate conclusively that a state is not to assume that liability of the third party will result in an actual payment. Thus, the state "may not withhold payment for services provided to a recipient if third party liability or the amount of liability cannot be determined, or payments will not be available, within a reasonable time." 42 C.F.R. §433.135(e)(2)(1979). The state may seek reimbursement from a third party either before or after Medicaid is provided. Id., at §433.135(f); see also the HHS Medical Assistance Manual, §§6-50-10 through 6-50-40, reprinted at CCH Medicare & Medicaid Guide, ¶14,749, at p. 6429. These requirements

are applicable to individuals as well as to organizations.[26/] HHS has consistently recognized that the responsibility of spouses for each other should be effected in the same manner as is that of other liable parties. Given the requirements of clause (B), it is as inappropriate to enforce the obligation of a spouse by deeming as it would be to enforce that of an insurance company.

Subsection (25) follows naturally from the necessary interpretation of clause (17)(D). The latter permits states to

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26/ Although the present regulations do not specifically identify individuals as potentially liable parties, the predecessor regulations did. See 42 C.F.R. §450.31(c)(1977). The changeover to the present regulations was effected with no "policy" or "substantive" alterations. 43 Fed.Reg. 45176 (1978). See also Medical Assistance Manual §6-50-21.A. The original implementation of subsection (25) was through SRS Interim Policy Statement No.2 (July 10, 1968), at 33 Fed.Reg. 10228-10229 (1968); it too cited individual liability as encompassed by subsection (25).

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enforce relative responsibility laws applicable to spouses. The former indicates that states should utilize those laws to collect payments from spouses who have failed to contribute. See Brown v. Stanton, supra, 617 F.2d, at 1231; Manfredi v. Maher, supra, 435 F.Supp., at 1114-1115. HHS' own observations regarding these provisions evidence no intent that clause (D) permits assumptions of availability otherwise forbidden. To the contrary, subsection (25) reinforces the apparent thrust of clause (D): that where legally liable spouses fail to make contributions which the state has determined should be made, it should enforce its spousal responsibility laws in the normal manner. 27/

27/ The Fifth Circuit concludes that if deeming is not permitted, clause (D) serves no function. Norman v. St. Clair, supra, 610 F.2d, at 1237. But that ignores its obvious purpose: to allow states to seek contributions from spouses through the standard channels, as subsection (25) underscores. The prohibition against deeming in (B) does not negate the significance of (D). See, e.g., Brown v. Stanton, supra, 617 F.2d, at 1230-1231;

(cont. p. 70)

E. Congress' anti-deeming posture follows from the relevant policy considerations

This statutory resolution by Congress was motivated by important policy considerations, as the court of appeals below noted and the Secretary now acknowledges. Primary among them is the economic effect of spousal separation, which destroys the spouses' previous ability to support each other.

> "[A]lthough there is a general expectation that spouses should support one another, their ability to do so is substantially undermined when one spouse is institutionalized. The expectation for support is based, in part, on the assumption that spouses maintain a common household, will share income and expenses, and therefore constitute a single economic unit. However, that assumption is undercut when a spouse is institutionalized." 45 Fed.Reg. 82256-82257

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27/ (cont.)

Hanke v. Nyhus, supra, 470 F.Supp., at 746; Manfredi v. Maher, supra, 435 F. Supp., at 1114-1115.

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(1980).[28]

The existence of a legal obligation does not mitigate the problem caused by separation; as one court succinctly observed: "Legal responsibility is not the real question in this type of case, but rather it is a question of the economic realities in a given situation." Burns v. Vowell, supra, 424 F.Supp., at 1142.

28/ Despite this unequivocal statement, defendants repudiate this analysis in their brief: "[T]he propriety of demanding that an applicant's spouse contribute to the costs of the applicant's medical care to the extent possible is not based on any notion of economies achieved by sharing a common household .... It is the marital relationship that is significant ...." Pet.Br. 20-21 (footnote omitted; emphasis supplied). Congress has explicitly recognized, however, the adverse impact of, and special considerations occasioned by, separation due to institutionalization; it treats those spouses as individuals, rather than as a couple, for purposes of computing the amount of SSI benefits. 42 U.S.C. §1382(e)(1)(B)(ii); see S.Rep.No. 94-1265, 94th Cong., 2d Sess., 27 (1976), reprinted at [1976] U.S. Code Cong. & Admin. News, 5997, 6021; see also Herweg v. Ray, supra, 619 F.2d, at 1287 (McMillian, J.).

The court of appeals specified the economic problems of deeming which emanate from separation: "Expenses can no longer be fairly characterized as jointly incurred, and 'deeming' no longer accurately reflects the economic norm." 629 F.2d, at 185 (Pet.App. 10a-11a).[29/] The Secretary has also recognized the harsh effect of deeming on the spouse at home:

> "[I]n [209(b)] States, the amounts that are protected for the non-institutionalized spouse's maintenance may be set at 1972 levels. These levels may be insufficient in light of the current cost of living. This may force the non-institutionalized spouse ... to try to live at levels that are inadequate for subsistence." 45 Fed. Reg. 82256 (1980); see, e.g., Manfredi v. Maher, supra, 435 F. Supp., at 1110; Franssen v. Juras, supra, 406 F.Supp., at 1377.

29/ See also, e.g., Foard v. Gibson, supra, CCH Medicare & Medicaid Guide, ¶29,679, at p. 10,144; Krygier v. Buscaglia, supra, CCH Medicare & Medicaid Guide ¶29,761, at p. 10,460 n.3; Franssen v. Juras, supra, 406 F.Supp., at 1377.
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By contrast, as the Secretary also acknowledges, pursuing support in the traditional manner does not have the same egregious and counter-productive effect:

> "[W]hen income is 'deemed', the spouse has less of an incentive actually to contribute the amount than if relative responsibility laws are used, because deeming has an adverse effect on the institutionalized individual, whereas relative responsibility laws affect the spouse in the community by requiring him or her to make support payments." 45 Fed.Reg. 82256 (1980).

The other side of the coin -- the effect of deeming on the institutionalized spouse -- is equally important. By including income of the non-applicant spouse, the state may determine that the applicant is not eligible. Moreover, even if she is eligible, the non-institutionalized spouse may fail to pay the deemed amount, so that the nursing home does not receive the full cost of care. The necessary result is eviction from the

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nursing home.[30/] The choice facing the non-institutionalized spouse is thus between a subsistence existence for him- or herself, and continued health care for the other. Franssen v. Juras, supra, 406 F.Supp., at 1377. It is a problem not easily resolved. And the "institutionalized individual is often literally helpless to temper the harshness of this dilemma." 629 F.2d, at 186 (Pet. App. 11a).

One "solution" is sometimes suggested: that the spouses divorce. See, e.g., Manfredi v. Maher, supra, 435 F.Supp., at 1110; Burns v. Vowell, supra, 424 F.Supp., at 1138. But this state infringement on marriage is unacceptable. 629 F.2d, at 186 n.14 (Pet.App. 11a n.14); Foard v. Gibson, supra, CCH Medicare & Medicaid Guide ¶29,679, at p. 10,145. Such a

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30/ See, e.g., 629 F.2d, at 186 (Pet. App. 11a); Brown v. Stanton, supra, 617 F.2d, at 1231; Rubin v. Creasy, supra, CCH Medicare & Medicaid Guide, ¶29,678, at p. 10,142; Manfredi v. Maher, supra, 435 F.Supp., at 1110; Franssen v. Juras, supra, 406 F.Supp., at 1377; 45 Fed.Reg. 82256 (3d column)(1980).

result, or even the suggestion of it, presents a classic instance in which "governmental regulation ... needlessly disrupt[s] people's lives." 629 F.2d, at 186 (Pet.App. 11a). Again, the Secretary recognizes this adverse impact from deeming, and notes that by limiting it, the likelihood of divorce will be reduced. 45 Fed.Reg. 82257 (1980).

The institutionalization of one spouse places a tremendous burden on couples, especially elderly ones who have been married for many years. The emotional trauma of illness and separation is exaggerated by the discovery that a retirement planned at a decent, if not luxurious, level will be thwarted by reduction of the non-institutionalized spouse's income to a subsistence level, with no opportunity to contest the deemed amount and -- if the state uses an arbitrary formula to calculate that amount -- no basis on which to contest it. The necessary fixed expenses of running a household are not diminished by the move of one spouse into an institution, yet the other spouse is suddenly expected to

survive -- to pay for rent, utilities, food, insurance, etc. -- on an income substantially reduced by deeming. That practice does not advance legitimate state goals; it masks real hardship and suffering under the guise of efficiency. "When ... one spouse needs special care and must live in a nursing home, it appears to us bureaucratically myopic to ignore the economic strain that institutionalization will cause to the spouse who remains at home." Franssen v. Juras, supra, 406 F.Supp., at 1378.

While Congress did not specifically discuss spousal deeming in the legislative history to the Medicaid statute, it did explicitly recognize the potential effect on individuals applying for assistance and their relatives. It carefully fashioned a mechanism which balances the interests and burdens of the states, the applicants, and their relatives. As a starting point, eligibility was not to be determined on the basis of income which is "in fact" not available. Indeed, the specific example cited by the congressional committees of potential

income not to be counted was "support orders from absent fathers, which have not been paid or contributions from relatives which are not in reality received by the needy individual." S.Rep. No. 404, supra, at 2018; H.Rep.No. 213, supra, at 67. It is inconceivable that Congress would recognize that an uncollected parental support payment, required by court order, was not available, while it permitted states to assume that a support payment, neither ordered nor made, was available from a spouse. "Available" cannot have diametrically opposed meanings depending on which relative is subject to a legal responsibility.

The applicant spouse is thus protected by the requirement that only actually available income be considered. Correspondingly, the other spouse is not to be subjected to conclusive presumptions that payments will be made, with the institutionalized spouse's welfare used as blackmail. The financial responsibility laws are the means to enforce spousal support requirements against the

responsible spouse. Clause (D) permits it, and subsection (25) corroborates that that is the appropriate route for the state to follow. It is the standard practice for requiring spouses to provide support, and the Medicaid statute does not suggest any divergence from it.

Congress established general guidelines to balance the interests of affected individuals and the states. The HHS policy allowing states to assume income available which is not in fact available repudiates the Congressional scheme and the underlying factors motivating that scheme -- factors which even HHS now recognizes. Deeming between spouses separated by institutionalization is inconsistent with the Medicaid statute, and should therefore be prohibited.

II. THE SSI STATUTE IMPOSES NO DEEMING REQUIREMENT UPON THE 209(b) STATES

Defendants analyze the Medicaid and SSI statutes at length to bolster their argument for required deeming in the 209(b) states. Pet.Br. 27-49. To a great extent, however, this discussion is

irrelevant to the issue of the case; more important, their ultimate conclusions are inaccurate, derived from a reading of the statute which is unsupportable.[31/]

Defendants' position is that, at a minimum, the 209(b) states must employ the SSI rules on pooling of income for determining Medicaid eligibility. Their general basis for this contention appears to be two dependent theories: that 209(b) status does not relieve opting states of the obligation to comply with SSI financial eligibility requirements and that Medicaid eligibility under the 209(b) option is potentially available only for individuals eligible for SSI. Under this reasoning, the pool of possible Medicaid recipients consists only of SSI eligibles, and from that pool, ultimate eligibility is established by application of the 209(b) rules. Thus, recipients in a

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31/ Since SSI does not exist in Guam, Puerto Rico, or the Virgin Islands, there is no way that this argument could possibly apply to those jurisdictions.

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209(b) state are necessarily a subset of all SSI eligibles. Consequently, defendants reason, at a minimum a state must apply the SSI rules.

The complexity of defendants' analysis is therefore occasioned by the need to explain how the numerous pieces of the SSI puzzle fit together. But this discussion ignores the very statute at issue: the 209(b) provision. Its language is explicit; it nowhere stands for or supports the analysis which defendants urge.

The distinctive and decisive feature of the 209(b) option is that it frees opting states from reliance on the SSI statute. With the advent of SSI in 1974, Congress tied Medicaid eligibility to SSI eligibility by requiring that all SSI recipients be automatically eligible for Medicaid. 42 U.S.C. §1396a(a)(10)(A). The 209(b) option untied this knot for those states which so chose. It defines a state selecting the option in terms which expressly indicate that that state is not required to follow the SSI rules: "no State not eligible to participate

in the State plan program established under subchapter XVI of this chapter [SSI] shall be required to provide medical assistance to any aged, blind or disabled individual ...." This opening section thus offers states the opportunity not to cover all SSI recipients by absolving them of compliance with subsection (10)(A). In plainer terms, this opening section says: "If you decide not to follow the SSI rules incorporated by reference through subsection (10)(A), you need not provide Medicaid to the aged, blind and disabled."[32/]

The second part of this first sentence of the 209(b) option[33/] then fills in the gap created by the first part of the sentence. Beginning with the word

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32/ The language of this portion of the 209(b) statute is essentially the negative form of nearly identical language establishing the general rule in subsection (10)(A).

33/ The first sentence is section 209(b) of Pub.L. 92-603, 86 Stat. 1381 (1972), with the second and third sentences added separately. Pub.L. 93-233, §13(a)(10)(D), 87 Stat. 962-963 (1973). All of 42 U.S.C. §1396a(f), however, is generally referred to as the 209(b) option.

"unless", the provision sets out the alternative method; it describes the option. That other side of the coin is coverage of all aged, blind and disabled in any month who would have been eligible for Medicaid in that month if the state were employing its January, 1972 rules.[34/]

A state thus has two distinct choices for coverage of the categorically needy: it can cover all SSI recipients, which is the standard procedure, or it can decide, via the 209(b) option, not to be linked with the SSI program and, instead, use financial eligibility conditions no more restrictive than those in effect on January 1, 1972.

Defendants reject this reading of the statute. While recognizing "that the intended operation and effect of the 209(b) option was ... to limit the obligations of participating states under 42 U.S.C. §1396a(a)(10)(A)," Pet.Br. 38, their

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34/ The remainder of the first sentence adds further provisos to this requirement, as will be discussed infra, at 88-90.

ultimate observation on 209(b) suggests a definite link with that subsection: "A state that exercised the option could only be required to provide medical assistance to those aged, blind or disabled individuals who were eligible for SSI benefits ...." Id., at 38 (emphasis supplied). Defendants devote the bulk of their analysis to explaining how, in light of other portions of the Medicaid and SSI statutes, this must have been Congress' intention.

Without this assumption, there is no basis for a requirement of minimum deeming in the 209(b) states; if the SSI standards are not superimposed upon a 209(b) state's 1972 eligibility conditions, then there can be no requirement that the SSI program's income pooling methodology be used. Defendants' assumption, however, has no support in the statute; its language implicitly and explicitly repudiates that analysis, and defendants' convoluted explanation as to what Congress must have intended only

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undercuts their argument.[35]

The 209(b) option nowhere states or implies that states must or can limit potential eligibility to the pool of SSI recipients. No language even distantly suggests such a restriction. As previously noted, the provision begins by exonerating opting states from the requirement that they comply with the SSI statute; it negates their tie-in with the SSI eligibility conditions through

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35/ Defendants state, for instance, that their conclusions are "virtually compelled by the language of the 209(b) option ...." Pet.Br. 41. Yet the option itself does not set maximum eligibility requirements, see infra, at 86, and defendants rely primarily on other components of the Medicaid and SSI structures.

subsection (10)(A).[36/] The very essence of the 209(b) option is its permission to the states to opt out of the otherwise required link to SSI.

The next part, which dictates the nature of the 209(b) states' obligation, is detailed and explicit. It does not, at any point, limit the application of those 1972 rules to individuals who are eligible for SSI. Congress did not impose that restriction, though it easily could have. The language of the relevant provision is therefore inconsistent with defendants' analysis.

Defendants support their contention by reference to the legislative history of 209(b), which indicates that its

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36/ In any event, (10)(A) requires that all SSI recipients be eligible for Medicaid, not that all Medicaid recipients be eligible for SSI. Even if 209(b) states were somehow still subject to (10)(A) -- which even defendants appear to reject (Pet.Br. 38) -- that subsection does not demand that they limit potential eligibles only to those who receive SSI.

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purpose was to allow states to save on Medicaid costs. Undoubtedly, that was a motivating factor behind Congress' approach, but it was not the sole consideration. While Congress sought to aid those states whose Medicaid roles would have greatly increased if required to follow the SSI rules, it did not limit the 209(b) option only to states with rules more restrictive than SSI. The option became a general vehicle for states to define their categorically needy in terms broader than the restricted SSI rules -- which set both the minimum and maximum standards available to a state. The 209(b) option may have been initiated solely to permit states to limit eligibility, but it evolved into a provision allowing states flexibility in establishing Medicaid eligibility. Minnesota, for instance, a state with generally liberal standards, selected the 209(b) option; its approach to income deeming, which is less restrictive than in the SSI states, reflects the inherent flexibility of the 209(b) option. See 629 F.2d, at 183 n.7 (Pet.App. 6a n.7).

The broad nature of the option is best reflected in the spenddown provision. The spenddown is the hallmark of the medically needy, who are those individuals with gross incomes over cash assistance levels but whose incurred medical expenses are deducted from their gross incomes to render them eligible. See 42 C.F.R. §§435.4, 435.301(a). This progressive feature of the statute permits those individuals whose medical costs render them indigent to obtain necessary health care even though they are not eligible for cash assistance. See, e.g., S.Rep.No. 404, supra, reprinted in [1965] U.S. Code Cong. & Admin. News, 1943, 2018.

When it created 209(b), Congress incorporated the spenddown component of the medically needy into the option. By so doing, Congress devised a more flexible and liberal provision than defendants are willing to admit. Inclusion of a spenddown for the categorically needy renders the option a considerable advancement over the unbending requirements of the SSI link. Congress allowed states to use their 1972 standards, but it required,

as the price for maintaining the status quo on eligibility levels, that the states include the most flexible component of the Medicaid statute. See S.Rep. 92-1230, 92d Cong., 2d Sess., 222 (1972).

The spenddown requirement not only undercuts defendants' general contention as to the restrictive nature of the 209(b) option; it also explicitly negates the suggestion that 209(b) is applicable only to SSI recipients. Regardless of what eligibility levels a state uses, the spenddown, by definition, will allow non-SSI eligibles to obtain Medicaid coverage. Even defendants recognize that fact: "[I]t is inconceivable that Congress intended to require states exercising that option to provide Medicaid coverage to any individual who is ineligible for SSI benefits, except as may result from the operation of the 209(b) spend-down clause." Pet.Br. 45-46 (emphasis supplied). This reluctant admission, though, defeats defendants' entire argument, for it acknowledges that there is no requirement of SSI eligibility as a pre-condition for application of the

209(b) option. Defendants offer no explanation as to how the option could be limited to SSI eligibles when the spenddown is not employed, yet still encompass everyone when the spenddown is used. There is no explanation: the option does not distinguish between SSI eligibles and others for purposes of determining Medicaid eligibility under its provisions. Its only requirement is that a state provide Medicaid to anyone who would have been eligible in 1972 (with or without the spenddown); there is no SSI overlay.[37/]

It is also evident that Congress never expected the 209(b) option to be tied to SSI rules or SSI eligibility to be a pre-condition for Medicaid eligibility under 209(b). The "amendment" to 209(b) demonstrates this. Congress added the last two sentences of 42 U.S.C.

37/ That states do extend Medicaid coverage to non-SSI recipients under the 209(b) option is apparent from cases discussing the option. See, e.g., Norman v. St. Clair, supra, 610 F.2d, at 1233-1234; Manfredi v. Maher, supra, 435 F.Supp., at 1109-1110.

§1396a(f) to the original 209(b) language for the express purpose of clarifying the status of individuals eligible under 209(b). See S.Rep.No. 92-553, 93d Cong., 1st Sess., 57 (1973). Recognizing that the option would necessarily result in rendering many people eligible for Medicaid who were not SSI recipients, thereby eliminating the standard basis for defining the categorically needy, Congress arbitrarily established definitions for the 209(b) states.

Thus, where a state does not have a medically needy program ("States which do not provide medical assistance to individuals pursuant to ... [42 U.S.C. §1396a(a)(10)(C)]"), everyone who is found eligible "shall be considered an individual eligible for medical assistance under ... [42 U.S.C. §1396a(a)(10)(A)]". Everone, in short, will be categorically needy and treated as if they were SSI recipients. By necessary implication, not all of them would actually be recipients; otherwise, there would be no need for the legal fiction. In this manner, Congress recognized that the 209(b)

option would result in the extension of categorically needy Medicaid coverage to many people who would not be eligible in the SSI states and who, by definition, were not SSI recipients.[38/]

Defendants' effort to superimpose the SSI "deeming" rules on the 209(b) states is further weakened by an analysis of those rules. HHS requires their application in the SSI states because of subsection (10)(A), see Fed.Reg. 2684-2685 (1977), but they were not developed for any of the policy reasons associated with deeming or because of HHS' evaluation of subsection (17).

Recognizing the "economy of scale" which exists when spouses live together, Congress reasonably required that the income and resources of an "eligible individual" and "eligible spouse" be pooled

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38/ Furthermore, in order to distinguish the categorically needy in 209(b) states with medically needy programs, the amendment to 42 U.S.C. §1396a (f) arbitrarily defined the categorically needy in those states as individuals receiving SSI or state supplementary benefits.

for determining SSI eligibility. 42 U.S.C. §1382(a)(2). Concerned that spouses might separate, however, in order to obtain individual benefits which, together, would be greater than a couple's benefit, Congress defined an "eligible spouse" to include a spouse who had been separated from the "eligible individual" for up to six months. 42 U.S.C. §1382c (b). Thus, if a couple sought to collect the higher benefits of individuals, they could only accomplish it by spending the first six months living separately on the income allocated for spouses living together -- the very antithesis of the economy of scale on which a couple's benefit is premised. The six-month rule was thus a tool aimed at discouraging voluntary and improperly motivated separations. H.Rep. No. 92-231, 92d Cong., 2d Sess. 150 (1971), reprinted in [1972] U.S. Code Cong. & Admin. News 4989, 5136; see Gray Panthers, 629 F.2d, at 184 (Pet. App. 8a); Herweg v. Ray, supra, 619 F.2d, at 1285-1286 (McMillian, J.); Mansfield v. Weinberger, 398 F.Supp. 965, 968-969 (D.D.C. 1975).

This provision is thus not related to the policies behind availability or deeming. For instance, where only one spouse is eligible, the pooling of income ceases after the first calendar month of institutionalization. 42 U.S.C. §1382c(f)(1); see 42 C.F.R. §435.723(d); Gray Panthers, 629 F.2d, at 184 n.9 (Pet.App. 8a n.9). "Availability" could not have a different meaning depending on whether one or both spouses were eligible. It seems undeniable, therefore, that the six-month rule has no connection with the concept of availability, either in the SSI program or in Medicaid. Still, defendants attempt to employ a rule developed specifically to discourage voluntary, fraudulent separations in a cash assistance program to determine Medicaid eligibility for spouses who involuntarily separate and who, in many instances, are not even eligible for cash assistance. The two situations are unrelated. See Schweiker v. Wilson, -- U.S. --, 101 S.Ct. 1074, 1085 (1981)(Powell, J., dissenting).

Indeed, Congress has itself recognized that separation caused by

institutionalization is of a different caliber than other separations. Although eligibility is determined by pooling income and assets, benefits for the non-institutionalized spouse are calculated as if he or she were applying as an individual. 42 U.S.C. §1382(e)(1)(B)(ii); see S.Rep.No. 94-1265, 94th Cong., 2d Sess., 27 (1976), reprinted in [1976] U.S. Code Cong. & Admin. News 5997, 6021; Herweg v. Ray, supra, 619 F.2d, at 1287 (McMillian, J.). In light of this provision, defendants' reliance on the six-month rule to determine Medicaid eligibility in 209(b) states is especially unconvincing.

The six-month rule bears no relationship to the issue of Medicaid deeming. Given its irrelevance to deeming, it is questionable whether that provision should even be applied in the SSI states. But there is certainly no basis for its applicability to the 209(b) states, which are not restricted by SSI eligibility criteria. See 629 F.2d, at 184 (Pet.App. 8a). The effort in SSI to prevent fraudulent separations has no bearing on the

issue of Medicaid deeming, and there is no statutory authority for its application in this context. The carefully drafted requirements for determining the availability of income in the Medicaid program should not be overridden by an irrelevant provision in a separate program which has no connection to determinations of Medicaid eligibility.

Financial eligibility determinations for Medicaid coverage in the 209(b) states are not governed by the SSI statute, according to the explicit terms of the 209(b) option. Consequently, there is no basis for requiring the 209(b) states to employ the SSI deeming rules.

CONCLUSION

The decision of the court of appeals should be affirmed.

Respectfully submitted,

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April 17, 1981

No. 80-756

ALEXANDER L. STEVAS
CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1980

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, AND ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, PETITIONERS

v.

GRAY PANTHERS

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

REPLY BRIEF FOR THE PETITIONERS

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In the Supreme Court of the United States

OCTOBER TERM, 1980

No. 80-756

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, AND ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, PETITIONERS

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1. The linchpin of respondent's argument is its repeated assertion (Resp. Br. 26, 42-46) that the term "available" income in 42 U.S.C. 1396a(a)(17)(B) only includes the income of an applicant's spouse if it is actually *contributed* to the applicant. The problem with this contention is that the term used in the statute is "available" and not "contributed." Moreover, the Secretary is expressly authorized by statute to define that term, and his regulations defining the term "available" income have never been construed by the

agency to exclude the income of an applicant's spouse simply because the spouse refused to contribute the income to the applicant but instead saved it or spent it on other goods and services.[1]

Section 1902(a)(17)(D) of the Act, 42 U.S.C. 1396a(a)(17)(D), clearly provides that (unless proscribed by the Secretary) participating states may consider the income of an applicant's spouse to be "available" to the applicant for the purposes of "determining eligibility for and the extent of medical assistance" (42 U.S.C. 1396a(a)(17)) to which the applicant is entitled under the Medicaid program. Yet respondent argues (Resp. Br. 17, 19, 39-40, 41-42, 44 n.11, 50, 60-70, 79) that this provision was intended only to allow participating states to enforce generally applicable civil or criminal relative responsibility statutes against the

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[1]Because the Secretary has never interpreted his regulations to prohibit consideration of the available income of a Medicaid applicant's spouse, whether or not actually "contributed," he has, as respondent concedes, "never moved to stop states from deeming" (Resp. Br. 48 n.14; see also *id.* at 2-3, 46-53, 56). But this merely indicates the agency's consistent, rather than its "schizophrenic" approach (*id.* at 48 n.14). Under this Court's precedents, substantial deference should be given to this consistent agency construction of its statute. See, *e.g.*, *New York State Department of Social Services* v. *Dublino*, 413 U.S. 405, 421 (1973); *Red Lion Broadcasting Co.* v. *FCC*, 395 U.S. 367, 381 & n.9 (1969); cf. *Udall* v. *Tallman*, 380 U.S. 1, 4 (1965).

Respondent also repeatedly quotes from the preamble to the regulations issued by the Secretary on December 15, 1980, in an effort to bolster its position. The preamble, however, contains the following passage (45 Fed. Reg. 82255):

> Should the Supreme Court grant review in *Gray Panthers*, it may be necessary to revise these regulations after the Supreme Court's decision on the merits. These regulations are based on the Court of Appeals' decision in *Gray Panthers*. That decision rejected the Department's legal analysis of the statute and ordered the Department to promulgate new deeming regulations specifying the circumstances under which and the extent to which deeming between spouses would be permitted based solely on the Department's analysis of the factors [the court] thought relevant.

spouses of Medicaid applicants or recipients. The language of the provision cannot bear that construction. Section 1902(a)(17) of the Act generally establishes guidelines for making initial Medicaid eligibility determinations. In making such determinations, the states must ignore "the financial responsibility of any individual for any [Medicaid] applicant or recipient * * * *unless such applicant or recipient is such individual's spouse* * * *" (42 U.S.C. 1396a(a)(17)(D)). Respondent makes no attempt to explain how its interpretation of clause (D) fits with the language and obvious purpose of Section 1902(a)(17). A state does not "tak[e] into account" the financial responsibility of a Medicaid applicant's spouse in "determining eligibility for and the extent of medical assistance" by *ignoring* the spouse's income in making those determinations and then filing a lawsuit against the applicant's spouse pursuant to a general support statute (assuming, of course, that the state even has such a statute).

Nor does respondent cite anything in the legislative history sufficient to support a reading of this provision so plainly at variance with its language.[2] Instead, respondent

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[2]Senator Hart's comment that the Medicaid Act would prohibit "many of the sad practices such as relative responsibility tests which have plagued Kerr-Mills programs in the past" (111 Cong. Rec. 15813 (1965)) does not address the question. As we noted in our opening brief (at 18-19 & n.10) the Act eliminated the "sad practices" by prohibiting consideration of the income of all relatives, except spouses and (in certain instances) parents. Similarly, Senator Ribicoff's statement "that contributions may be required only from spouses * * *" (111 Cong. Rec. 15804 (1965)) plainly supports the Secretary's reading of the statute and hardly suggests that the contributions could only be required by filing thousands of independent lawsuits. See *Brown* v. *Stanton*, 617 F. 2d 1224, 1234 (7th Cir. 1980) (Pell, J., dissenting), petition for cert. pending, No. 79-1690. Similarly, Senator McNamara's description of the bill, considered in context, does not support respondent's assertion (Resp. Br. 63) "that the purpose [of clause (D)] was to

observes (Resp. Br. 64) that "[t]here is no indication in the legislative history that Congress ever contemplated that clause (D) would expand the impact and effect of relative responsibility laws." Since Congress' primary concern was to establish guidelines "for determining eligibility for and the extent of medical assistance" (42 U.S.C. 1396a(a)(17)) under the Medicaid program, that is not surprising. Like the other parts of Section 1902(a)(17), clause (D) establishes guidelines for determining eligibility and the amount of assistance under the Medicaid program and, contrary to respondent's assertion, is not exclusively related to state enforcement of generally applicable support laws.

Respondent asserts (Resp. Br. 68-70) that Section 1902(a)(25) of the Act, 42 U.S.C. 1396a(a)(25), somehow supports its construction of Section 1902(a)(17)(D). Under Section 1902(a)(25) of the Act, a state Medicaid plan must

> provide (A) that the State or local agency administering such plan will take all reasonable measures to ascertain the *legal liability of third parties to pay for care and services* (available under the plan) *arising out of injury, disease, or disability,* (B) that where the state or local agency knows that a third party has such a legal liability such agency *will treat such legal liability as a resource of the individual* * * * *for purposes of*

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avoid the use of relative responsibility laws" or that clause (D) had anything to do with state enforcement of such generally applicable civil or criminal laws:

> First. The family responsibilty [*sic*] provisions which imposed hardships on the children and grandchildren of elderly applicants for aid—and which often served to deter otherwise qualified individuals from seeking help. The new bill would limit the application of the family responsibility provision to the spouse, if any, of the applicant.

111 Cong. Rec. 15876 (1965).

> *[Section 1902(a)] (17)(B),* and (C) that in any case where such a legal liability is found to exist * * * the State or local agency will seek reimbursement * * *.

42 U.S.C. 1396a(a)(25) (emphasis added). This provision requires the state to consider the legal liability of a third party as a "resource" "available" to the applicant within the meaning of Section 1902(a)(17)(B); see also 42 C.F.R. 433.135(e)(1). It is difficult to understand how it supports respondent's assertion that Section 1902(a)(17)(D) only allows participating states to enforce generally applicable support statutes (or that the word "available," as used in Section 1902(a)(17)(B), means "contributed"). Section 1902(a)(25) of the Act, 42 U.S.C. 1396a(a)(25), was added in the 1967 Amendments to the Social Security Act (Section 229, Pub. L. No. 90-248, 81 Stat. 904). The purpose of paragraph (25) was not to allow the states to take into account the income of an applicant's spouse in making Medicaid eligibility determinations; Section 1902(a)(17)(D) had already accomplished that. The primary focus of Section 1902(a)(25), rather, was to require the states to make reasonable efforts to recover from unrelated third parties such as insurance companies or tort feasors.[3]

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[3]See, *e.g.*, H.R. Rep. No. 544, 90th Cong., 1st Sess. 123 (1967):

> *Payment for services by a third party.* It is obvious that many people need medical care because of an accident or illness for which someone else has fiscal liability; for example, a health insurer or a party who is determined by a court to have legal liability. In order to make certain that the State and the Federal Governments will receive proper reimbursement for medical assistance paid to any eligible person when such third-party liability exists, a new requirement would be included in title XIX. Under this provision, the State or local agency would have to take all reasonable measures to ascertain the legal liabilities of third parties to pay for covered services. Where the legal liability is known it would be treated as a resource of the recipient. In addition, if medical assistance is granted and legal liability of a

More important, Section 1902(a)(17)(B) and (D) of the Act, as interpreted by the Secretary, permit the states to consider the income of an applicant's spouse in determining Medicaid eligibility. Nothing in the Secretary's third party liability regulation cited by respondent (42 C.F.R. 433.135(e)(2)) purports *to require* participating states to ignore the income of the applicant's spouse in making Medicaid determinations and then file a lawsuit to recover money that it was never required to pay.

2. Respondent erroneously asserts (Resp. Br. 3-4, 16, 22, 29, 34-38, 81-82, 96) that the language of the 209(b) option makes the provisions of the SSI statute irrelevant to the issues in this case. According to respondent (Resp. Br. 34-35) "[t]he release from the SSI rules is established with these words: '. . . no State not eligible to participate in the State plan program established under subchapter XVI of this chapter [SSI]. . . .' " Like respondent's other statutory arguments, this one is difficult to square with the language upon which it is based. The SSI program is not a "State plan program"; it is administered by the federal government. Thus, the "State plan program established under subchapter XVI" referred to in 42 U.S.C. 1396a(f) is obviously not the SSI program.

As used in Title XIX of the Social Security Act (42 U.S.C. 1396 *et seq.*), the term "state" generally includes Guam, Puerto Rico, and the Virgin Islands. See 42 U.S.C. (Supp. III) 1301(a)(1). The "State plan program established under subchapter XVI" referred to in 42 U.S.C. 1396a(f) is the old combined categorical assistance program (42 U.S.C. (1970 ed.) 1381 *et seq.*) and not the SSI program. Since the old categorical assistance programs were not repealed in Guam,

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third party is established later, the State or local agency must seek reimbursement from such party. The Federal Government would receive its share of any reimbursement received.

See also S. Rep. No. 744, 90th Cong., 1st Sess. 184 (1967).

Puerto Rico, and the Virgin Islands (see Pub. L. No. 92-603, Title III, Section 303(a) and (b), 86 Stat. 1484), those jurisdictions are "states" eligible to participate in the "State plan program established under subchapter XVI." Thus, contrary to respondent's assertion, the words "no State not eligible to participate in the State plan program established under subchapter XVI of this chapter" (42 U.S.C. 1396a(f)) did not effect any "release from the SSI rules" (Resp. Br. 34-35). Rather, Congress simply made it clear that the 209(b) option was unavailable to Guam, Puerto Rico, and the Virgin Islands.[4]

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[4]Respondent correctly notes (Resp. Br. 89-90) that the Secretary's interpretation of the 209(b) spend-down provision results in the somewhat anomalous situation that a 209(b) state without a "medically needy" program may be required to cover an individual who would be ineligible in an SSI state without a "medically needy" program. With this arguable exception, however, the Secretary has always understood the relationship between the SSI statute and the Medicaid statute to prohibit 209(b) states from using Medicaid eligibility criteria for the categorically needy that are more liberal than those used in determining SSI eligibility. For example, the *Medical Assistance Manual* expressly states that:

> Eligibility conditions from the January 1972 medical assistance plan which are more liberal than those applied in the SSI program may not be retained for Medicaid coverage of the aged, blind and disabled as categorically needy * * *.

Medical Assistance Manual, Part 4, Subpart 4-20-20 (4), at 13 (1976); see also, *e.g.*, 39 Fed. Reg. 9512 (1974); 40 Fed. Reg. 60075 (1975); 42 Fed. Reg. 2687 (1977). As explained in our opening brief (at 36-44), the language of the 209(b) option, its legislative history, its purpose, and the relationship between the Medicaid and SSI statutes support the Secretary's conclusion that Medicaid eligibility criteria for the "categorically needy" in 209(b) states cannot be more liberal than those applicable under the SSI statute. Of course, 209(b) states, like SSI states, may choose to cover any of the optional groups provided for by Congress.

Respondent cites (Resp. Br. 87) Minnesota as an example of a 209(b) state that has Medicaid eligibility criteria more liberal than those of the SSI statute. We are informed that the Secretary has been engaged in discussions with Minnesota officials intended to secure voluntary compliance with the statute and the Secretary's regulations without the need for beginning formal proceedings under 42 U.S.C. 1396c.

Finally, like the court below (Pet. App. 8a), respondent contends (Resp. Br. 92-96) that it is inappropriate to require use of the SSI rules under the Medicaid program because the rules were intended to prevent fraud and are not related to "the policies behind availability or deeming" (Resp. Br. 94). This argument completely misconceives the nature of the analysis that led to the regulations. As set out more fully in our opening brief (at 27-49), the regulations are based upon the relationship between the two statutes and not the assumption that the reasons for adopting the rule in the SSI context are applicable in the Medicaid context. The reasons that prompted Congress to adopt the rules in the SSI context are essentially irrelevant. What is important is that *the income of an applicant's spouse is in fact considered (whether or not actually "contributed") in determining SSI eligibility.* The Medicaid statute does not prohibit the consideration of the income of an applicant's spouse (see our opening brief at 17-27). Hence, the Secretary's decision to require all participating states to consider such income if it would be considered in determining SSI eligibility is a reasonable construction of the statute and should be upheld.

3. Respondent accuses the Secretary of over-complicating this case. Although the issue presented does involve the interrelation between two complex statutory schemes, we agree that the essential question may be simply stated. When a Medicaid applicant or recipient is institutionalized, and his or her spouse has extra income sufficient to pay all or part of the applicant's medical expenses, who should pay those expenses: the spouse or the taxpayers? We submit that the answer provided by the Secretary's regulations is consistent with the Medicaid statute and reflects the intent of Congress.

For the foregoing reasons and the reasons stated in our opening brief, it is respectfully submitted that the judgment of the court of appeals should be reversed.

WADE H. MCCREE, JR.
Solicitor General

APRIL 1981

DOJ-1981-04

No. 80-756

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

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Petitioners,
v.
GRAY PANTHERS,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the District of Columbia Circuit

BRIEF *AMICUS CURIAE* OF JOHN H. FOARD, LILA CARTER, YOLANDA AND QUENTIN ALLEN, OSCAR AND GRACE HYDE, AND ELIZABETH AND JAMES BROWN, URGING AFFIRMANCE

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INTEREST OF AMICUS CURIAE

John H. Foard, Lila Carter, Yolanda and Quentin Allen, Oscar and Grace Hyde, and Elizabeth and James Brown have a vital interest in the outcome of this case because they are Medicaid recipients and spouses of recipients whose lives have been dramatically effected by the federal regulations which the Gray Panthers, respondent, challenge in this litigation. The *amici* are residents of North Carolina, Utah, and Indiana which are states whose Medicaid programs must comply with the federal "deeming" regulations, the validity of which is the subject-matter of this cause. The *amici* themselves all initiated litigation in their home states challenging the legality of regulations, policies and practices which each of their respective states adopted in order to implement the challenged federal regulations.

The *amici* are not governmental bodies or associations with a particular viewpoint. They are all persons who either live in nursing homes or whose spouses live in nursing homes. They are individuals of very modest means and resources whose lives were hurt by their states' implementation of the challenged federal regulations. They have a very personal stake in the outcome of this case because it will significantly impact on their ability to meet the basic necessities of their lives, affect their entitlement to twenty-four (24) hour professional care at a nursing home, affect their long-standing marriages and even the preservation of their own personal dignity as they live out their remaining years as senior citizens. They join the Gray Panthers, respondent, in urging this Court to affirm the decision of the Court of Appeals, 629 F.2d 180 (D.C. Cir. 1980).

ARGUMENT

The Medicaid program provides funds to participating states for the provision of medical assistance to aged, blind and disabled persons (among others) whose income and

resources are insufficient to meet the costs of necessary medical services. This case is focused on the legality of certain federal regulations (42 C.F.R. §§435.734, 436.602, 436.711 and 436.821) which the Secretary of Health and Human Resources, petitioner herein, has adopted pursuant to his federal responsibility to administer the jointly funded (federal and state) Medicaid program, 42 U.S.C. §1396 *et seq.* These federal regulations apply only to those states who have chosen to participate in the Medicaid program pursuant to the option found at 42 U.S.C. §1396(f). Fifteen (15) states have chosen this option and are known as "§209(b)" states. These §209(b) states must administer their Medicaid programs at the state level within the confines of all applicable federal law, including the challenged federal regulations.

At the heart of the legal controversy facing the Court is the question of who is going to pay the cost of an aged, blind or disabled Medicaid recipient's nursing home care. The federal regulations found unlawful by the Court of Appeals enabled the §209(b) states to set up the following general scheme: (a) the Medicaid recipient residing in the nursing home keeps a minimum amount (usually between $25.00-$30.00) of his own monthly income for his personal needs and pays the remaining amount to the nursing home; (b) the Medicaid recipient's non-institutionalized spouse is permitted to keep some arbitrary sum of money (unrelated to her own needs and obligations) out of her own income and required to pay all the rest to the nursing home; and (c) the §209(b) state pays whatever part of the nursing home expense remains after the Medicaid recipient and his spouse have made their payments. *Amici* have all filed class action lawsuits in their respective states to challenge the regulatory schemes which were governing the payment of nursing home expenses for Medicaid recipients. In each case the *amici* prevailed in their litigation efforts with one common result: the non-institutionalized spouse's obligation to the nursing home was tailored to her individual ability to make payments.

This result foreclosed the threat to the Medicaid recipient-spouse residing in the nursing home of eviction from the home for non-payment by his spouse. The result also allowed Medicaid recipient-spouse to remain secure in the knowledge that his spouse did not have to choose between meeting her own basic needs and making payments to the nursing home. Each of their cases will be dramatically influenced by the outcome of the Court's decision in this case.

A. *Foard v. Gibson*, CCH Medicare & Medicaid Guide, ¶29,679 (W.D. N.C. 1979), No. C-C-78-0319

John Foard, age 63 years, and his wife Alma Foard live in North Carolina and have been married for more than 37 years. Mrs. Foard suffers from multiple sclerosis. Mr. Foard worked for years as a machine operator and supervisor and a service station operator. He was forced to retire from his job after he suffered a severe heart attack September 14, 1974. Despite his own disability, Mr. Foard cared for his wife night and day until August 17, 1977, when she was hospitalized. A month after her hospitalization, Mrs. Foard was transferred to a nursing home for skilled nursing care. She later returned to her home, but Mr. Foard was not able to care for her. After five days Mrs. Foard called an ambulance to take her back to the skilled nursing facility where she has remained to the present time.

Mrs. Foard is a Medicaid recipient and pursuant to North Carolina's §209(b) plan, she was allowed throughout 1978 to keep $29.00 out of her $214.00 monthly Social Security Disability check but was required by the North Carolina plan to pay the remaining $185.00 to the nursing home. Mr. Foard was allowed to keep $162.33 of his $356.20 Social Security Disability check and was required by the plan to pay the remaining $183.87 to the nursing home.

Mr. Foard's average actual monthly expenses were $313.00. After he paid his contribution to his wife's care, he

had $162.33 left to meet his monthly expenses of $313.00. It was impossible for him to meet his fixed monthly expenses. He had the choice of going without basic necessities of life or jeopardizing his wife's health by failing to pay the mandated contributions. Mr. Foard expended all of his savings supporting himself and his wife. He cut off the propane gas to his stove in order to save $4.00 per month. Since he could no longer heat his food, he resorted to eating cornflakes and skim milk for most meals. Before he had exhausted his savings, Mr. Foard drove to the nursing home three times per week. To save money, he reduced his trips to two times per week. During the winter he spent early evenings in bed in order to save on fuel costs. He cancelled all his life insurance policies because he could not pay the premiums.

Mr. Foard's only alternative to paying the mandated contribution was to sign a "Separation Agreement" drafted by the North Carolina Department of Human Resources which stated that he did not intend to live with his wife of more than thirty-five (35) years should she be released from the nursing home. If he signed this agreement, North Carolina would have freed him of any obligation to make payments to the nursing home. But John Foard refused this option because he feared that it would adversely impact on his wife's emotional and physical health.[1]

For approximately eighteen years, Eddie Carter, now deceased, was employed with the State of North Carolina at Central Prison in Raleigh, North Carolina. In December, 1974, he was released from his employment due to difficulties concerning his memory and ability to follow instructions. After hospitalization, he was diagnosed as suffering from organic brain syndrome. Lila Carter, the widow of Eddie Carter, cared for Eddie Carter at their

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[1] See the testimony of Juanita Holland, Appendix A. at 11-12 at the preliminary injunction hearing in *Foard v. Gibson* regarding North Carolina's "Separation Agreement."

home in Clayton, North Carolina, from January 1975, until September, 1975. Mr. Carter needed constant attention as he was prone to wandering off. Also, he had periods of violent activity when he would attempt to assault his wife. In September, 1975, Mr. Carter was admitted to a nursing home; and he resided there almost continuously until his death in November, 1979.

As in the case of Mrs. Foard, Mr. Carter participated in North Carolina's Medicaid program which required that both she and her husband make payments on her nursing home care while Medicaid paid the remainder. In 1978 Mr. Carter derived his total income from Social Security Disability benefits ($335.30 per month) and State Retirement payments ($216.37 per month). He was allowed to retain $29.00 of his total income of $551.67 for his personal needs but he was required to pay the balance of his income to the nursing home. During this time, Mrs. Carter derived her entire income from Social Security Disability benefits ($241.10 per month). She was allowed to retain $162.33 per month from her own income but was required to pay the balance to the nursing home.

Mrs. Carter's average actual monthly expenses were $245.00. It was impossible for her to meet her fixed monthly expenses on $162.33. She had the choice of going without basic necessities of life or jeopardizing her husband's health by failing to pay the mandated contribution.

On May 15, 1978, Mrs. Carter was told that Mr. Carter would be put out on the street in front of the nursing home on May 22, 1978, unless she could pay the nursing home the amount deemed for part of April, 1978 and the month of May, 1978. She managed to borrow the money from neighbors in order to continue her husband's necessary medical care. She constantly faced the threat that Mr. Carter would be evicted because Medicaid would pay only a portion of the cost of institutionalization. Mrs. Carter testified at the Preliminary Injunction hearing on March

21, 1979, that her husband faced imminent eviction if she did not immediately pay her entire mandated contribution.[2] Of course Mrs. Carter could have also availed herself of North Carolina's "Separation Agreement" but she refused, explaining that "When I married my husband, I said for better or worse. I took my marriage vows very seriously and just because he's ill, I do not intend to divorce him now if I have to live off of bread and water." Appendix at 6.

In October, 1978, John H. Foard and Lila Carter filed a class action complaint in the United States District Court for the Western District of North Carolina, Charlotte Division, challenging North Carolina's regulations, policies and practices used in implementing the federal "deeming" regulations. On March 21, 1979, after conducting a hearing, the district court entered an order certifying a class and preliminarily enjoining the North Carolina officials from their "deeming practices and procedures which require that an arbitrary portion of the income of the non-institutionalized spouse be 'deemed' available for the care of the institutionalized spouse without regard to actual living costs of the non-institutionalized spouse."[3] The state officials did not appeal the entry of the preliminary injunction and the cause has remained inactive ever since, pending a decision by this Court in the instant cause.

B. *Allen v. Califano*, No. C-78-212 (D. Utah, Aug. 23, 1979), *appeal pending*, No. 79-2167 (10th Cir.)

Yolando and Quentin Allen and Oscar and Grace Hyde filed their class action complaint in the United States District Court for Utah in 1978 against both the Utah officials who administer that state's Medicaid program and against the Secretary of Health and Human Services of the federal government. On August 23, 1979, the district court

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[2] See Mrs. Carter's testimony Appendix at 5.

[3] Preliminary Injunction Order (March 27, 1979), p. 4

granted plaintiffs' motion for summary judgment against both sets of defendants. The Utah officials were enjoined from assuming (or "deeming") that a non-institutionalized spouse had specific sums of money available for payment to her Medicaid recipient-spouse's nursing home. Further, the Court declared the same federal regulations which are the subject of this cause to be illegal and ordered the federal government to issue new regulations, just as the district court below had done in this cause. The defendants in *Allen v. Califano* appealed the decision to the United States Court of Appeals for the Tenth Circuit (No. 79-2167) wherein all proceedings on the appeal have been stayed by that court. However, in an order entered on December 10, 1980, the Tenth Circuit specifically denied the federal government's motion to stay the district court order.

The plaintiffs in this Utah case have been struggling with the problem of obtaining and paying for nursing home care for several years. It has been at great personal sacrifice. Their lawsuit, as related above, did not remove their problems; rather, it merely removed the dilemma of the non-institutionalized spouse having to choose between meeting her own basic needs and preserving the continued nursing home care of her Medicaid recipient-spouse, without having to utilize the expedient but personally distasteful option of divorce. An examination of the facts personal to the Allens and Hydes will illustrate the harsh effect of the deeming regulations.

Mr. Allen suffers from serious diabetes and the totally incapacitating effects of a stroke. He cannot walk and has no control over his bodily functions. He requires constant attention and care from skilled personnel. Without such care, he will not continue to survive.

Eight years ago Mrs. Allen had to sell the house in which she and Mr. Allen had lived in Tremonton, Utah, in order to pay for her husband's care. The proceeds have long since been exhausted. To support herself, she joined the labor force, at age 58, for the first time in her life. She has not

worked long enough at her job to accumulate any retirement benefits. Now, at age 66, she must continue working as long as possible in order to support herself and acquire a minimal amount of savings on which to live after retirement.

Her present expenses consume all of her take-home pay, however. In order to remain as close as possible to her husband's nursing home, she has been purchasing the apartment in which she has been living at the cost of $229.00 per month. Three years ago, when her husband first applied for Medicaid, her gas and electricity bills average $50.00 per month and the minimum telephone bill was $9.00 per month. At that time, even economizing as much as possible, food expenses still ran $150.00 per month in order to provide herself adequate nourishment. She also suffers from a back injury and has paid for her own medical and dental expenses. Traveling at least 20 miles each day to work and to visit her husband, she spent at least $40.00 on gasoline, oil, and maintenance for her automobile. Her car is now eleven years old and has been having mechanical problems, and, needless to say, all these expenses have skyrocketed over the last three years.

The Allens have no savings account and no other assets. All of Mr. Allen's monthly Social Security benefits are taken to pay for his nursing care. Mrs. Allen has worked hard too, to provide for herself from her earnings. She desperately wants her husband to continue receiving his nursing care, but if part of her earnings are taken to pay for his care, too, she will no longer be able to provide for her basic necessities.

Mrs. Allen does not know how much longer she will be able to work. She is willing to continue working as long as she remains in good health and there is a place for her in the labor market. Beginning her work experience at age 58 was very difficult, but she has felt it important to be as self-sustaining as possible; she has never desired to burden anyone. Her only wish has been to stay by her husband and

see that he receives the best possible care. If she is able to contribute further toward his care, all of her continued efforts indicate that she will.

Grace Hyde is institutionalized in the Geriatics Ward of the Utah State Hospital. She suffers from brain damage and seizures. Mrs. Hyde was operated on for brain aneurisms in 1960. Due to inadequate medical care in the post-operative state, complications set in, and she developed severe mental aberrations. These caused her to experience several violent seizures, necessitating skilled medical attention for her continued well-being. In December, 1976, after she was taken to the University of Utah Medical Center for emergency treatment, the state district court ordered that she be involuntarily committed, and she has remained in the State Hospital ever since. Her aneurisms and mental difficulties continue, and the doctors attending her report that her future mental health is questionable. She is not improving, and without continued skilled medical attention, she will not survive.

Oscar Hyde, at age 75, has worked all his life to be self-sufficient, also has established certain maintenance costs for his home, and has exhausted all his savings to pay for his wife's care. Since he has retired his only income is a small pension and a Social Security benefit. His wife's Social Security benefits are paid toward her care. Because her doctors report that she responds well to Mr. Hyde's visits, for years now he has devoutly traveled from Salt Lake City to Provo, Utah, to visit her in the State Hospital, a total of 120 miles round trip, at least a couple of times a week. His gasoline expenses are high. He buys his wife's clothing and other personal items from which she can derive some pleasure in life and even medical supplies which the Hospital does not provide her. His telephone bills are also high, because of the collect calls from the State Hospital. Mr. Hyde pays for his own medical and dental expenses, having exhausted their insurance on Mrs. Hyde's care. He has found that frequent exercise and recreation are

essential to keeping himself fit—mentally as much as physically—relieving his anxieties over his wife, and maintaining social relationships and his own emotional stability. While these efforts may save his health in the long run, nothing is free. And even if they could not be considered cost-saving measures, when one has worked an entire life long, only to be beset by so many problems, a little recreation can hardly be considered exorbitant.

Mr. Hyde has spent close to $25,000.00 for his wife's care, as well as his private insurance and her own Social Security benefits. The Hydes have no resources left. If Mr. Hyde's benefits are reduced to the minimum public assistance level to pay for his wife's care, too, he could not meet those most basic living expenses, which were established long before his wife was committed to the Hospital, and his lifetime goal of self-sufficiency will disappear from his life forever. He is not opposed to paying a reasonable amount for his wife's care; indeed, he has; and if he is able to contribute further toward her care, all of his enduring efforts indicate that he will.

C. *Brown v. Stanton*, 617 F.2d 1224 (7th Cir. 1980), *pet. for cert.* pending No. 79-1690 (filed April 25, 1980)

James Brown, now 76 years of age, is an adjudicated incompetent whose son, Michael, acts as his guardian. Mr. Brown, suffering from chronic brain syndrome, is unable to remember simple facts, refuses to change clothes or bathe, and is unable to control his body functions. Unable to care for or control her husband and upon a physician's recommendation, Elizabeth Brown, James' wife of thirty-five (35) years, arranged to have him moved into a nursing home near her Indianapolis, Indiana home. At this same time (October, 1978), she contacted the Welfare Department to request that Mr. Brown be certified as eligible for participation in Indiana's Medicaid program. The Welfare Department found James to be Medicaid eligible but required that Mrs. Brown, in accordance with

a uniformly applied mathematical formula embodied in state regulations, pay part of the nursing home expenses out of her own income and resources.

The Browns, as their counterparts in Utah and North Carolina, were in a dilemma because Elizabeth was unable to pay her assigned share to the nursing home and James desparately needed professional, twenty-four (24) hour care. Rather than obtain a divorce, which would have rendered Mr. Brown totally eligible in his own right, they challenged the state regulations in the United States District Court for the Southern District of Indiana, Indianapolis Division. After a trial on the merits, the district court, on February 16, 1979, certified a plaintiff class and declared that the Indiana regulations were contrary to 42 U.S.C. §1396a(a)(17) insofar as they acted to arbitrarily and irrebuttably assume or deem that certain portions of Mrs. Brown's income and resources were "available" for the cost of her husbands' care when, in fact, they were not. The court ordered the state welfare officials to tailor Mrs. Brown's financial obligations to her individual ability after taking into account all of her other needs and obligations. On appeal, the Seventh Circuit affirmed the district court's order for individualized treatment of non-institutionalized spouses such as Mrs. Brown.

However, the Seventh Circuit also addressed a "second level of inquiry" and held that Indiana could not assume that an able spouse would always actually pay her assigned share to the nursing home. The court reasoned that if Indiana were allowed to deem an able spouse's contribution to the cost of the spouse's nursing home care, then upon her refusal or failure to actually so contribute, the Medicaid recipient would be in an extremely vulnerable position "raising the spector of eviction" from the nursing home. 617 F.2d at 1226.

But more importantly, the Seventh Circuit held that 42

U.S.C. §1396a(a)(17)[4] could not be internally consistent with any other interpretation. Specifically, the Seventh Circuit held that Indiana was authorized by subpart (D) of §1396a(a)(17) to require non-institutionalized spouses to defray part of the cost of their spouse's nursing home care, but that subpart (B) required Indiana, in determining the exact amount of Medicaid funds which it would pay to the nursing home to take into account only that income and resources which the spouses actually paid to the nursing home.[5] The Seventh Circuit explained that in the event that an able, non-institutionalized spouse refused to meet her financial obligations to the nursing home, Indiana would be required under subpart (B) to make an upward adjustment in the amount of Medicaid benefits it pays on behalf of the recipient; and then, in accordance with subpart (D), the state could take all steps necessary to make full and proper collection from the unwilling spouse.

The appellate court thus fully resolved any apparent conflict between the requirement of subpart (B) to consider

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[4] That statute provides:

(a) A state plan for medical assistance must—

(17) include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient . . ., (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child . . .

[5] The Senate Finance Committee in speaking of Section 1936a(a)(17) in their report upon the Medicaid statute stated:

Another provision is included that requires states to take into account only such income and resources as . . . are actually available to the applicant or recipient . . .

These provisions are designed so that the states will not assume the availability of income which may not, in fact, be available or overvaluate income and resources which are available. S.Rep. No. 404, 89th Cong., 1st Sess. 78, reprinted in [1965] U.S. Code Cong. & Ad. News 1943, 2018.

only actually available income and resources and the authorization of subpart (D) to impose financial requirements on non-institutionalized spouses. Furthermore, it removed the possibility of a Medicaid recipient being harshly evicted from a nursing home whenever his able spouse refused or failed to meet her obligations. "To hold otherwise would be to deny an eligible recipient his full benefits because of an improper action of his or her spouse." 617 F.2d at 1231.

CONCLUSION

Amici, with respondent, urge this Court to remove the terrible dilemma which so many blind, disabled and older citizens are facing every day as they must choose between meeting the needs of one spouse or continuing the nursing home care of the other spouse. Nor, of course, should they be disgraced with the "simple" but pathetic option of an expedient divorce. *Amici* respectfully urge with respondent that the decision of the Court of Appeals for the District of Columbia be affirmed.

Respectfully submitted,

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Appendix

APPENDIX A

Testimony of Lila Carter and Juanita Holland given on March 21, 1979 in *Foard v. Gibson*, CCH Medicare & Medicaid Guide, ¶29, 679 (W.D. N.C. 1979), No. C-C-78-0319.

LILA CARTER,

a witness called by the plaintiff, having first been duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MS. CARY:

Q Ms. Carter, state your name and address.

A Lila Carter, 502 West Second Street, Clayton, North Carolina, 27520.

Q Are you married?

A Yes, ma'am.

Q What is the name of your husband and where does he live?

A Eddie A. Carter and he is now in Johnston County Memorial Nursing Center, Smithfield, North Carolina.

Q How long has he been in the nursing home?

A Since September 5, 1975.

Q Why does he live at the nursing home instead of at home with you?

A Because of a mental state he is in, I cannot care for him at home. It was a twenty-four hour job.

Q What is the source of your husband's income and how much is it?

A He gets three hundred thirty-five dollars and some few cents—I can't remember exactly—Social Security. He gets two hundred thirty dollars and some few cents retirement from the state, which amounts to approximately five sixty-some.

Q What is the source of your income and how much is it?

A I get Social Security, two hundred forty-one dollars and ten cents each month.

Q Do either of you have any other income?

A No, ma'am.

Q Do you have an estimate as to how much the nursing home bill is each month?

A Six hundred and seventeen dollars a month.

Q I'm asking about the nursing home bill.

A I'm so sorry. It runs between a thousand and eleven hundred dollars a month.

Q Do you have any insurance that can help you pay that bill?

A No, ma'am.

Q How is the bill paid now?

A I pay six hundred seventeen dollars per month and then Medicaid picks up the tab for the remainder.

Q Do you then pay both of his checks and part of your own check?

A Yes, ma'am.

Q Ms. Carter, can you estimate how much your monthly bills are for electricity?

A Approximately fifty-five or more dollars a month.

Q What about for oil?

A About twenty-three or more per month.

Q Car insurance?

A I think my car insurance is approximately ten—fifteen dollars a month. I can't remember exactly, somewheres thereabouts.

Q Car repairs?

A About fifteen per month, thirty a month—no, I guess about fifteen a month, something like that, I'm sorry.

Q What about gas?

A About thirty a month.

Q What do you spend for food?

A Well, at the very minimum, fifty a month.

Q What about vitamins?

A I do take vitamins and they run about ten dollars a month.

Q Do you have a telephone?

A Yes.

Q How much is that?

A Eleven.

Q Do you pay property taxes?

A Yes, we do pay property taxes.

Q About how much is that?

A That runs—let's see if I can remember—about fifteen or more dollars per month. I'm not sure.

Q That's averaging it out.

A Averaging it out per month, yes, uh-huh.

Q Do you have any other bills you have to pay on a regular basis?

A Well, not on a regular basis other than an extra twenty-five that I'm having to pay to the nursing home at this time.

Q Can you tell the Court what, if anything, you have had to do without while you have been trying to survive on the one hundred sixty-two dollars?

A A lot of things. Before this happened, my husband and I would go out to dinner approximately a couple of times a week. If we took a notion to take a little trip to the coast or the mountains, something of that sort, we would just take off on a Friday and come back on Sunday afternoon—all this was cut out—movies. All these things completely had to be cut out. Also, I was used to going to the beauty parlor to get my hair done once a week and I can't do that anymore. There's a number of things. I don't know if I can remember them all. Anyway, I do know that there's quite a number.

COURT: What is your age?

A Sixty-two.

Q Do you have to take a special diet?

A Yes, I do and I cannot afford it on the income that's left over for me to live on.

Q And do you now buy new clothes?

A No, I haven't had any new clothes since my husband became ill and we exhausted our savings that we had.

Q How long ago was that?

A Since—actually, our savings run out about the time, the first month that I put him in the nursing home.

Q That was?

A September 5, 1975.

Q Can you remember what you had to do without during the first six months after you put him in the nursing home?

A All these things I have just mentioned I had to do without because our savings was exhausted at that time.

Q Did you have to take out any loans?

A Yes. My husband and I had very good credit references and we had Master Charge cards and I have borrowed from First Citizens Bank in Clayton, North Carolina, several times to try to keep my head above water.

Q And you're still paying that loan back?

A Yes, ma'am.

Q Have you ever not been able to pay the full amount of your patient liability, or I should say what the nursing home bills you for each month?

A Yes, ma'am.

Q When you couldn't pay that amount and you fell behind in your payment to the nursing home, what happened?

A Well, for instance, when my Social Security started in June of '77, there was a little mix-up at the Social Security Services and I paid in June what I was billed for, but in July they came up with a much larger bill.

Q That's what caused you to fall behind?

A I was billed for more than our income.

Q And then in May of last year, what happened?

A That's what I'm taking about, in May of last year. At the time—let me explain a little further so it can be understood. I didn't know which way to turn when this particular thing happened, so I did go to Legal Aid to ask for help. Marsha Stine assigned, helped me get an extension to pay a little a month—no, I'm sorry. Let me explain further. I went to the administrator and asked if I could do this—I had to go to the owner of the nursing home. He said I could pay a little a month. The first day of May of '78, there was a letter mailed from Dunn, from a Gilmore Parrish, owner of the nursing home, and I was told that I would have to pay the ninety-nine dollars, which is what I was lacking in catching it up, by the eight of May, five o'clock, or I would have to take my husband from the nursing home.

Q Were you able to raise that money?

A No. Then is when I went to see Wake Legal Aid and Marsha Stine was appointed to me to kind of help me with this. She called Mr. Parrish and talked with him and got another thirty-day extension on this.

Q So your husband was not evicted from the nursing home.

Q No.

Q If your husband were to be evicted from the nursing home, is there another nursing home near your home where you could have him placed?

A No, ma'am.

Q Ms. Carter, has anyone ever informed you of a way you could avoid paying part of your Social Security check to the nursing home each month?

A Yes, my husband's case worker, Donna Pittman, told me she hated to mention it, but said, you can divorce your husband and you will not be liable for your Social Security, you will not have to give it up. This is the only way I can advise you that you can get by without having to pay it.

Q Did you consider getting a divorce?

A No.

Q Why not?

A When I married my husband, I said for better or for worse. I took my marriage vows very seriously and just because he's ill, I do not intend to divorce him now if I have to live off of bread and water.

Q At the present time, how much do you owe the nursing home in addition to your monthly bill of six hundred seventeen dollars.

A Approximately four hundred dollars right at the present time.

Q When did you receive notice of this extra amount of money?

A In February, February, around the first few days of February is when my February bill came in from the nursing home.

Q Has the nursing home contacted you about this additional four hundred dollars?

A Well, when this happened, I went down and talked to the administrator and he couldn't explain it to me. So I was advised to call Gilmore Parrish at Dunn and talk with him. I did this and he said that definitely I would have to pay it so, again, I came to Marsha for help, Marsha Stine.

Q What arrangements have you been able to make to pay this additional four hundred dollars?

A She talked to him and worked quite a while trying to help me, about half a day, and so she worked it out with him that I could pay twenty-five dollars in February and twenty-five in March.

Q That is in addition.

A In addition to the six hundred seventeen, plus the sixteen to eighteen dollars I pay for laundry and his medicine.

Q How long have they told you they will work with you on the twenty-five dollars a month?

A Until today, the 21st of March, 1979.

Q If the Court does not grant you the relief you seek today, what will you do?

A I don't know. I just really don't know what I'll do. I'm at my wits end. If they put him out, I can't care for him at home and I don't how what I'll do.

Q They have given you until today.

A Until today.

MS. CARY: Your Honor, I have no further questions of this witness.

JUANITA HOLLAND,

a witness called by the plaintiff, having first been duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MS. HAYES:

Q Give us your age.

A Fifty-three.

Q Current address?

A 5338 Melynda Road here in Charlotte.

Q Are you currently employed?

A Yes, ma'am.

Q Where is that?

A National Mattress Company here in Charlotte.

Q What do you do for them?

A I'm a sewing machine operator.

Q Were you married to the late Billy Wade Holland?

A Yes, ma'am.

Q When did he pass away?

A February 22 of this year.

Q What was the cause of his death?

A Brain cancer.

Q When did he first learn of that?

A In 1972.

Q Was he working at that time?

A Yes.

Q Where was that?

A At Pharr Yarns in McAdenville.

Q How did his illness in 1972 affect his ability to continue working?

A Well, when it first started, he was out mowing the grass and he came in and something happened to his head and I

rushed him to the doctor. He thought he had a sunstroke and it wasn't a sunstroke so he gave him some tablets to see if it would throw it off, stop them. It wasn't that and these little strokes kept coming on ever so often.

Q Did he eventually have to quit his job?

A He sure did.

Q Were you able to care for him at home?

A I cared for him as long as I could, as much as I could.

Q And then what did you do to arrange for his care?

A I had to stop working and care for him at home until I had to put him in a nursing home.

Q At the time you placed your husband in the nursing home, did you seek medical assistance from your local Department of Social Services?

A Yes, ma'am.

Q Did they inform you that you would have to have a patient liability or payments from you toward his nursing home bill?

A Yes, ma'am.

Q Mrs. Holland, as far as you remember, was February of 1978 a typical month for you and your husband in terms of bills and income?

A It was a bad time.

Q Well, was it any worse than any of the rest of 1978?

A I would say that the whole year was bad for me. It really was bad.

Q Taking February as just a point in time, can you tell me, were you working at that time?

A Ye, I was working.

Q And your husband was in the nursing home?

A Yes, ma'am.

Q And do you remember approximately what you were making a month in terms of your take home pay?

A About three hundred twenty a month.

Q And what was the source of your husband's income?

A His Social Security check was two hundred eighty-eight dollars a month.

Q Was there any other income to the family for you or your husband?

A No, ma'am.

Q Do you remember what your patient liability, that is, what you had to pay to the nursing home was at that time?

A I had to put his check and then I had to put one hundred sixty-eight dollars of my check every month, which was for his patient liability which was four hundred twenty-five dollars.

Q So you had to pay all of his Social Security plus some of your own wages?

A Yes, ma'am.

COURT: His Social Security plus one hundred sixty-eight dollars of yours?

A Yes, sir.

Q What was your patient liability, total patient liability?

A Four hundred twenty-five.

Q During the several years in which you were bound to pay a patient liability, can you tell us how this affected you economically?

A Well, after I put him in the nursing home, in those years I had to put my house up for sale, him and I had bought a boat and I had to, I got this man up there and he had taken up the payments on it and gave me two hundred dollars. I had to sell it and we had a riding lawn mower and I sold it. I sold—he had bought a chain saw and I had to sell it and I

also stored my furniture at my son's when I put the house up for sale. Finally I had to get it and sell it piece by piece to people that would but it and give me what they could for it.

Q During this period of time, were there things that you needed that you had to go without?

A Yes, ma'am, there sure was. For instance, I was supposed to get my glasses changed and which I have never had the money to get them changed with. There has been times I needed to go to the doctor for a physical and other things and I could not go and I haven't had any new clothes in, I know, four years.

Q You mean that literally.

A Literally, right.

Q During this time, were you able to arrange for a stable place for yourself to live?

A No, ma'am. I had to—I moved in with my mother and then from there I moved in with my sister. It was just from one place to the other that I would go, the ones that could help me, because I did not have the money to pay the rent myself on an apartment or anything like that. I couldn't afford it.

Q Did your Department of Social Services worker ever mention a separation agreement to you?

A Yes, ma'am, she did.

Q Who was this?

A This was Mrs. Mattice.

Q What county?

A In Gaston County.

Q That's where you were living at the time.

A Right.

Q Exactly what did Mrs. Mattice say to you about the separation agreement?

A Well, I got a letter stating that his liability had went up and I took it over there to her and I told her I just couldn't afford to pay that much and buying his medicine also. She told me that I could get a separation paper from my husband and I wouldn't have to pay all of this and I told—she asked me what did I think about it and I said, well, I just don't think I can go through with that. I said because I love him too much and I want to do for him as long as he lives and I want to be with him as long as I can. I just told her I didn't think I could go through with it because the way she talked, I couldn't ever see my husband any more or do for him, you know.

Q So at that time, you refused to sign such an agreement.

A I sure did.

Q Mrs. Holland, did you eventually sign one of these separation agreements?

A Yes, ma'am.

Q When was that?

A When I talked to you. When I first came to talk to Legal Aid and talked to you and you talked to me about it and you explained to me that it would not cause me that I could not see my husband any more, that I could also see my husband and continue doing for him, when I went to the nursing home, what I could.

Q Was there anything else that you knew at that time that affected your decision to sign the separation agreement?

A Yes, ma'am. I just couldn't keep paying all that much money and all. I had just got to the place where I didn't know what to do. I was just at the place where I just didn't know which way to turn.

Q Do you remember what month that was that you finally signed?

A That was in April of '78.

Q When you finally signed the so-called separation

agreement in April of 1978, do you remember how that signing affected you emotionally?

A Yes, ma'am, I sure do. It really hurt me. It upset me and I cried for two days and two nights and I finally had to go to the doctor. It upset me so bad, I finally had to go to the doctor and get something for my nerves. I'm still taking the nerve pills and it really upset me. It made me sick to know that I would have to sign a separation paper to get out of paying so much to a nursing home for my husband which is passed away now. I'm still upset.

Q Have you ever had any problem with your nerves or sought medical attention for your nerves before that time?

A No, ma'am. I have always been in good health. I have never had any trouble with my nerves or anything.

Q Prior to the time you signed that separation agreement and your liability was reduced, were you able to keep up with the amount of payment that was expected from you?

A No, ma'am, I couldn't.

Q Did you ever have any trouble from the nursing home on account of this?

A Yes. I went up there to the nursing home. I would go every Sunday and see him and every Saturday that I possibly could and I went up there one Sunday and the lady from an office came upstairs while I was visiting and she sent word for me to come to her office and I went. She told me that the nursing home had taken—some new people had taken over the nursing home and she said they would have to have this back money that I owed or they would have to take further steps, that this man was demanding this money.

Q What kind of effect did this have on you?

A It upset me so bad until I cried all the way home and then on Monday is when I called you and told you about it.

Q Do you know why the nursing home didn't take those "further steps" that they indicated they were going to take?

A Well, when I called you and told you about it, you told me you could put a stop to it. That's what you said.

Q Now that your husband has passed away, do you still have an outstanding bill at that nursing home?

A Yes, ma'am, twelve hundred and something dollars is hanging over my head to pay.

Q Do you have any means to pay that?

A No, ma'am, I do not.

MS. HAYES: That's all the questions that I have.

No. 80-756

In the

Supreme Court of the United States

OCTOBER TERM, 1980

RICHARD S. SCHWEIKER, Secretary of Health and Human Services, and Administrator, Health Care Financing Administration,
Petitioners,

v.

GRAY PANTHERS,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the District of Columbia Circuit

BRIEF *AMICUS CURIAE* OF THE STATE OF INDIANA, URGING REVERSAL

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INTEREST OF AMICUS CURIAE

The State of Indiana has a vital interest in the outcome of the instant case, since Indiana has adopted and applied

both state regulations and a state statute pursuant to the regulations issued by the Secretary, which were challenged by the Respondent. At stake is the authority of the Secretary to promulgate regulations, under the provisions of 42 U.S.C. §1396a(a)(17), which concern Medicaid eligibility for married persons and the calculation of their income and resources. These regulations permit states such as Indiana to adopt as a matter of policy certain procedures for taking into account the income and resources of an applicant's spouse and for considering that income and resources to the extent the individual states would have done so in 1972 under their state plans.

Indiana believes that Congress intended to permit states which choose to do so to retain eligibility criteria from the state plans of January 1, 1972, as an incentive, to assure that these states will continue to participate in the Medicaid program. Absent this option, a greater financial burden would fall upon the states—a burden which some states could ill afford to bear in today's difficult economic times. Indiana, as a participant in the Medicaid program, is bound by law to comply with federal statutes and regulations concerning the program. The result of a decision invalidating the challenged regulations would be to enlarge suddenly and greatly the cost of participating in the Medicaid program, since Indiana's statutory and procedural framework for determining income and resources would fall as lacking authority in federal law.

Indiana is among the states which chose to implement the congressional option and retain its 1972 eligibility standards. If the regulations are stricken, this option would effectively be eliminated, and both the State and its citizens would be faced with the prospect of having to make greater expenditures to remain within the program, or to attempt to obtain funds elsewhere. Indiana therefore files its brief *amicus curiae* in the belief that the Secretary had the authority to adopt the regulations challenged herein and

may have been obliged to do so to effectuate congressional intentions. Both the district court and the appellate court ignored these critical concerns in finding for the Respondent.

ARGUMENT

I. The Secretary acted within his authority in adopting regulations which provide guidelines as to the consideration of income.

The decision of the Court of Appeals for the District of Columbia Circuit demonstrates both the complexity of the issue of Medicaid eligibility and benefit calculation and the confusion of many courts as to the so-called practice of "deeming." The term requires considerable discussion, since no aspect of the Medicaid program can be viewed in isolation.

As is often stated, Medicaid is a cooperative state-federal program which was created in order to assure that needy persons would, under specific criteria, have access to medical care in the form of a wide range of preventive, diagnostic, and ameliorative services. Prior to January 1, 1974, participating states were permitted to operate programs for the benefit of the "categorically needy", including the aged, the blind, the disabled, and families with dependent children. On that date, the federal Supplemental Security Income (SSI) program began, with benefits paid by the Secretary of the then-entitled Department of Health, Education, and Welfare (hereinafter "the Secretary") to persons in the first three of the above categories under federal eligibility criteria. 42 U.S.C. §1381 *et seq.* The participating states had since the enactment in 1965 of the Medicaid program been obliged to provide medical assistance to all persons receiving benefits under the three categories replaced by SSI as well as to recipients of Aid to Families with Dependent Children (AFDC). Since the various state programs contained some differences in the amount of income and resources an

applicant could have in qualifying for assistance, the new SSI provisions would in some states have resulted in a much greater number of persons being found eligible for benefits with accompanying medical assistance. 42 U.S.C. §1396a(a)(10).

States were as a result provided an option, often referred to as the 209(b) option since the latter number was the designation of the option in the 1972 amendments to the Social Security Act. P.L. 92-603; 42 U.S.C. §1396a(f); Appendix, Petition for Certiorari, at 36a. Under this section, each participating state could choose to continue to determine eligibility for medical assistance of blind, aged or disabled persons under the income and resource standards in effect on January 1, 1972. States which retained these historical eligibility criteria are generally called "209(b) states," while the states which rely solely upon SSI eligibility criteria for determining who shall receive medical benefits are labelled commonly the "SSI states."

Important differences separate the 209(b) states from the SSI states. Prominent among them is the requirement that state plans in the 209(b) states include a "spend-down" provision, so that persons whose incomes are too high to qualify under state eligibility rules can contribute this excess income toward their care and thereby obtain medical assistance. 42 U.S.C. §1396a(f); *Williams v. St. Clair*, 610 F.2d 1244 (5th Cir., 1980). A second major distinguishing fact becomes apparent in the calculation of an applicant's income and resources, where the applicant is married, following differentiating regulations effective April 13, 1977. 45 C.F.R. §248.3. In SSI states, the income and resources of each spouse, where both apply or are eligible for benefits, are considered to be available to support the other while they actually live together and for six months after the month in which they cease to live together. 42 C.F.R. §435.723; *Norman v. St. Clair*, 610 F.2d 1228 (5th Cir., 1980), *cert. pet. pending*. If only one of the

spouses is eligible for SSI, and they cease to live together, under regulations in effect when this case was instituted, the income and resources of the other spouse cannot be considered available to the applicant unless the income and resources are actually contributed after the month in which they cease to live together. *Id.*

On the other hand, 209(b) states must observe the dictates of 42 U.S.C. §1396a(a)(17)(B) and (D), which provide that only "available income and resources" be considered in regard to an applicant or recipient and that the financial responsibility of any individual except the applicant's spouse or, where the applicant is a child who is blind or disabled or is under 21 years old, parent, must be disregarded. 42 U.S.C. §1396a(f); *Norman, supra.* The statute places the responsibility for setting guidelines for the states and for approving state plans with the Secretary. 42 U.S.C. §1396a(a)(17)(B),(D). There is no cut-off date after which the applicant's spouse's income can no longer be considered; the spouse or parent could therefore be expected to continue to contribute after the six-month SSI state period has expired. There are two separate questions to be decided in a thorough analysis of the so-called "deeming" issue. First, it must be determined if the Secretary could issue regulations to structure the 209(b) states' approaches to the matter; that is, it must be decided if "deeming" is permissible. Second, it must be determined how, in a general way, this process is to occur. The specific details involved in the calculation are left to the states.

The explicit language of the statutory section, set forth at page 35a of the Appendix to the Petition for Certiorari, requires that the Secretary set standards. 42 U.S.C. §1396a(a)(17)(B) and (D). The import of subsection (D) is clear; since it says that no person other than a spouse or a parent can be held financially responsible, the implication is inescapable that a spouse or parent *can* be declared responsible. 42 U.S.C. §1396a(a)(17)(D). If that necessary conclusion is not reached, a cardinal tenet of statutory

construction would be ignored: the courts must give effect to every portion of a statute to achieve legislative intent, since the goals of Congress are to be implemented. *Colautti v. Franklin*, 439 U.S. 379 (1979); *United States v. Kimbell Foods, Inc.* 440 U.S. 715 (1979), on remand *U.S. v. Crittenden*, 660 F.2d 478 (5th Cir., 1979).

It has been stated that it is what Congress intended, not what courts may feel, that should determine what is appropriate to the regulatory process. *E.I. duPont de Nemours & Co. v. Train*, 430 U.S. 112, 138 (1977); *National Resources Defense Council, Inc. v. Costle*, 568 F.2d 1369, 186 U.S. App.D.C. 147 (C.A.D.C., 1977). The administrative agency, to whom Congress has delegated the operation of its programs, must be afforded considerable discretion in choosing the methods the agency finds are appropriate for each program. *Tennessee Gas Pipeline Co. v. Fed. Energy Regulatory Commission*, 606 F.2d 1094, 196 U.S.App.D.C. 161 (C.A.D.C., 1979) *cert den.* 445 U.S. 920. The agency, because of its intimate knowledge of each program, has a peculiar competence as to determinations regarding statutory implementation. *Fuhrman v. Dow*, 540 F.2d 396 (8th Cir., 1976). Thus, deference to an agency interpretation should be the rule, absent an indication that the agency's choice is '...unwarranted in law or without justification in fact.' *Noell v. Bensinger*, 586 F.2d 554, 558 (5th Cir., 1978); *Quern v. Mandley*, 436 U.S. 725 (1978).

It is reasonable to conclude that Congress intended to permit the Secretary to promulgate regulations which would clarify and document a small part of an exceedingly complex program. The legislative branch cannot be expected to enact statutes which deal minutely with each part of the income—resources calculation. As this Court declared, in *Batterton v. Francis*, 432 U.S. 416, 425 (1977):

> In a situation of this kind, Congress entrusts to the Secretary, rather than to the courts, the primary responsibility for interpreting the statutory term. In exercising that responsibility, the Secretary adopts

> regulations with legislative effect. A reviewing court is not free to set aside those regulations simply because it would have interpreted the statute in a different manner. American Telephone & Telegraph Co. v. United States, 299 U.S. 232, 235-237, 57 S.Ct. 170, 172, 81 L. Ed. 142 (1936).

Here, the Secretary has taken a common-sense approach in adopting regulations which permit the consideration of available spousal income and resources, in the knowledge that the 209(b) option was necessary to assure certain states' participation in the medicaid program. *See* S.Rep.No. 404, 89th Cong., 1st Sess. 4, *reprinted in* [1965] U.S.C.C.A.N. 1943, 2018; [1972] U.S.C.C.A.N. 4989, 5013, 5187. The expectation of spousal contribution is reasonable and necessary.

Furthermore, 42 U.S.C. §1396a(a)(17) and 42 U.S.C. §1396a(f) do not by their wording or by implication apply only to states which have spousal or relative responsibility laws. *Herweg v. Ray*, 619 F.2d 1265, 1272 (8th Cir., 1980), *cert. pet. pending*. Nor do these statutory sections require an actual contribution of income or resources; as the *Herweg* court stated, no reach of the imagination can equate "available" with "actually contribute." *Herweg, supra*, at 1271-1272. The statutes likewise do not require that an unwilling spouse must be sued in order to effect contribution. By necessary implication, then, a 209(b) state might as reasonably determine the amount to be contributed and to enforce that decision through medical assistance regulations, at such lower expense and at much less inconvenience, as through financial responsibility laws. *Norman v. St. Clair, supra*, at 1237. The Secretary just as reasonably concluded that regulations implementing that statutory scheme should be adopted, to enact more fully the intent of Congress and to channel the otherwise undirected discretion of the 209(b) states. The regulations provide particular guidance to states such as Indiana, whose spousal support law in inapplicable in this area. I.C. (1978) 31-1-9-10.

Since the regulations herein concerned followed statutory wording quite closely, it is difficult to see how such regulations could be called arbitrary, capricious, or

otherwise defective as a matter of law without any real challenge to the underlying statute. The law allows states to choose to utilize eligibility standards of January 1, 1972, to determine who should receive medical assistance, including in the income-resource calculation available income of a spouse or of a parent of a minor or blind or disabled child. 42 U.S.C. §1396a(a)(17)(B), (D); 42 U.S.C. §1396a(f). The regulations state that, in a manner not more restrictive than was employed on January 1, 1972, the available income of a spouse (or parent of a minor or blind or disabled child) may be considered in determining an applicant's eligibility. 42 C.F.R. §§435.723, 435.734, 436.602. If the above-cited statutes are proper, the regulations must be legitimate as well. The apparent contention that the statutes permit if not require the enforcement of spousal or relative responsibility laws, while the regulations cited above cannot be utilized in the same manner as would be adopted and approved in each 209(b) state plan, is artificial and unrealistically burdensome.

The Secretary has adopted regulations which are reasonably related to legitimate ends, and their validity must be upheld. *Mourning v. Family Publications Service*, 411 U.S. 356 (1973), 42 U.S.C. §1302.

II. The so-called practice of "deeming" may be accomplished in a permissible manner.

The Respondent herein has adopted the use of "deeming" as a label for the process undertaken and continued by the 209(b) states, which label connotes as a sort of code word an administrative practice which to Respondent can never be proper. That is, the sense of the phrase "consider available income" has been replaced by what has been presented as a frightening and automatically inexcusable distortion, "deeming." This is a trap into which several unwary, unquestioning, or overly hasty commentators—and some courts—have fallen. The label has been applied in a general manner to the procedures of the 209(b) states, ignoring the fact that the income calculation rules are slightly different

in each. An overly vague term such as "deeming" is but a catchword, failing to deal with specifics of the eligibility computation and obscuring the need for a fiscally and legally reasonable approach to the medical assistance area.

To say simply that "deeming" is always impermissible is to neglect both the normal goal of construing statutes—and here regulations—so as to allow them to be upheld and the usual flexibility in interpreting such noncriminal statutes which the courts employ to ensure agency freedom to act. It is the conclusion of many courts that a reasonable and factual evaluation of a noninstitutionalized spouse's income and resources can properly justify an expectation of contribution, whereas an arbitrary presumption cannot be supported. *Herweg, supra*, at 1269-1270; *Norman, supra*, at 1240-1242; *Franssen v. Juras*, 406 F.Supp. 1375, 1379 (D. Or., 1975). The *Norman* decision goes farther in upholding a uniform needs allowance to be protected for the ineligible spouse. *Norman*, at 1232, 1242-1243. The Fifth Circuit Court of Appeals recognized that a non-standard expense deduction scheme might unduly benefit the wealthy spouse who could shift all income and resources to the other spouse, who might incur unnecessary or extreme expenses to keep from making contribution. *Norman*, at 1238. In light of such potential administrative obstacles, including the decision as to what expenses could be seen as "acceptable" in kind and amount, this standardized approach may be more effective as a means of assuring enforcement.

However, the statute mandates that the states *consider* the ineligible spouse's income, with no requirement of individualization, to the extent it is available. If that is "deeming," the fault lies with the statute and the existence of the 209(b) option. Indiana, however, believes the statutory language suffices to convey the intent of Congress. It seems that the real issue is procedural and definitional, not the propriety of considering spousal income. Thus, it is difficult to see why the Secretary's

regulations cannot be interpreted, consistent with constitutionality, in a flexible way to do what Congress did not preclude. It must be presumed that Congress intended the result actually achieved, since the statutes have not been amended.

The matter of just how the 209(b) states may calculate income and resources requires an examination of each state's adminstrative framework, since the federal regulations are more general in stating that available income may be considered. That careful scrutiny is not a component of this cause, which does not refer to state procedures. In light of the questionable standing of the Respondent to make its blanket charge of the invalidity of the federal provisions, the Court should act consistently with the long-standing policy of deference and accept the agency's choice of methods. *Ford Motor Credit Co. v. Milhollin*, 444 U.S. 555 (1980); *Warth v. Seldin*, 422 U.S. 490, 498-499 (1975); *Hunt v. Washington State Apple Advertising Comm.*, 432 U.S. 333, 343 (1977). As was noted in *Dandridge v. Williams*, the choice for states as well as for the federal government is whether to support some persons adequately and some less so, or to give insufficient funds to everyone but give a small amount to more individuals. 397 U.S. 471 (1970). A third choice, in these difficult economic times, may be to cease giving any assistance at all. The latter should be avoided if possible, for the needs of many citizens continue to grow; all potential and reasonable sources of funds to help reach the goal of preventing utter destitution for as many persons as possible must be reached.

CONCLUSION

As the Petitioners will thoroughly set forth the statutory analysis necessary to the disposition of this matter, the State of Indiana would not burden the Court by repetition. Instead, the State must respectfully urge with the Petitioners that, as a matter of legal and logical necessity, the decision of the Court of Appeals for the District of Columbia Circuit be reversed and the validity of the Secretary's regulations declared.

Respectfully submitted,

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